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Informing clients of confidentiality limits and subsequent child abuse reporting decisions: the role of dissonance

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Informing clients of confidentiality limits and subsequent
child abuse reporting decisions: The role of dissonance

by

Katherine M. Nicolai

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TABLE OF CONTENTS

	<u>Page</u>
ACKNOWLEDGEMENTS	iii
INTRODUCTION	1
METHOD	35
RESULTS	43
DISCUSSION	91
REFERENCES	129
APPENDIX A: COVER LETTER AND SURVEY RESPONSE CARD	135
APPENDIX B: SURVEY INSTRUMENT	138
APPENDIX C: REGRESSION TABLES	146

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INTRODUCTION

Confidentiality

Confidentiality may be defined as the ethical obligation of therapists to refrain from disclosing information communicated to them in their professional capacities by clients. Although confidentiality is an ethical practice based on professional standards, the confidential nature of the therapist-client relationship is also recognized by state codes that regulate the practice of psychotherapists (DeKraai & Sales, 1984.) For example, in cases of unauthorized breaches of confidentiality, practitioners may be faced with civil liability suits (Swoboda, Elwork, Sales, and Levine, 1978).

Historically, the confidentiality of therapist-client communication has been the foundation upon which the profession of psychotherapy has rested. According to some theorists (e.g., Epstein, Steingarten, Weinstein & Nashel, 1977), psychotherapy would be virtually impossible without an assurance of confidentiality because of the extremely private nature of the information that is disclosed. In fact, some have advocated absolute confidentiality of the therapist-client relationship (e.g., Dubey, 1974; Siegel, 1976).

American Psychological Association (APA) guidelines have consistently emphasized the integral nature of confidentiality in psychotherapy, stating that "Psychologists have a primary

obligation...to respect the confidentiality rights of those with whom they work..." (p. 1607, APA, 1992). There are, however, certain conditions under which psychologists are legally mandated to breach confidentiality. For example, the clinician's "duty to warn and/or protect" potential identified victims of serious harm threatened by clients in therapy is a legally mandated breach of confidentiality first articulated in the landmark Tarasoff case (Tarasoff v. Board of Regents of the University of California, 1974). Furthermore, mandatory child abuse reporting statutes require therapists to breach confidentiality when they suspect that a child has been abused; this particular mandated breach of confidentiality is the focus of the present study.

In the following sections, several components of the ethical dilemma posed when clinicians are legally required to breach confidentiality are explored. Issues concerning informing clients of confidentiality limits is especially relevant to the present study, and is examined first.

Informed Consent and Confidentiality

Informed consent to psychotherapy requires that clients are provided with information that may have an impact on their decisions about treatment. The ethical principles underlying informed consent are twofold. The principle of autonomy suggests that clinicians must respect clients' rights to make their own decisions regarding treatment. The second

principle underlying informed consent is beneficence, which demands that clinicians protect the well-being of clients by promoting good and preventing harm (Kitchener, 1984).

Practically speaking, informed consent procedures strive to protect the autonomy and well-being of clients by providing them with information pertaining to alternative modes or forms of therapy, fees and financial obligations, the limits of confidentiality, and potential risks and benefits of therapy (Handelsman, Kemper, Kesson-Craig, McLain, & Johnsrud, 1986). Each piece of information may have an impact on whether any one individual ultimately chooses to become a client in psychotherapy. Moreover, each piece of information may influence other treatment decisions. For example, information about fees may have an impact on how often a client will schedule therapy sessions (e.g., once per week, once per month, etc.). Most relevant to the present discussion is the fact that information regarding the limits of confidentiality may have a significant impact on what material a client will choose to disclose in therapy.

Informing Clients of Confidentiality Limits

The ethical principles of the American Psychological Association (1992) state that "unless it is not foreseeable or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant" (p. 1607). Baird and Rupert

(1987) found that 71% of their psychologist respondents approved of an ethical guideline recommending that clients be informed in advance of confidentiality limits. In another survey of practitioners who treat adolescents, the provision of information on the limits of confidentiality was perceived as the most important element of informed consent (Beeman & Scott, 1991).

Proponents of informing clients of confidentiality limits suggest that this practice can benefit the therapeutic process. Everstine et al. (1980) offer this "proverb" to therapists: "When in doubt, provide your client with information...to the extent that the potential experiences of therapy are revealed to a client early in treatment, the therapeutic relationship will be nurtured" (p. 831). Rosen (1977) adds that when a practitioner conveys respect for the rights of clients, clients will be more comfortable disclosing personally-relevant information.

Noll (1974) contends that as ethical professionals, therapists must inform clients of possible risks of treatment, including the risk of self-incrimination. In this regard, some practitioners have advocated caution when prewarning clients of confidentiality limits (e.g., Roth & Meisel, 1977; Faustman & Miller, 1987). Specifically, the provision of confidentiality information may deter some clients from seeking therapy because they fear the consequences of

disclosing self-incriminating information. Thus, some practitioners have voiced concerns that it is possible that prewarning clients of limits might discourage some individuals who would likely benefit from treatment from seeking treatment, and potential or actual victims of abuse are less likely to be identified and protected.

Recent surveys have indicated that less than one third of practitioners utilize written informed consent procedures with their clients in therapy (Faustman, 1982; Handelsman et al., 1986). Furthermore, informed consent forms used by practitioners often do not contain information specific to confidentiality limits (Handelsman et al., 1986). Baird and Rupert (1987) found that only about half of their sample of psychologists informed clients of confidentiality limits during the first therapy session, and about 12% told clients that all information disclosed in therapy was confidential. A study by Nicolai and Scott (1994) indicated that although about three-quarters of licensed psychologists said that they always or usually provide information about confidentiality limits to clients, nearly 20% indicated that they sometimes, rarely, or never provide this information, and 5% misleadingly tell clients that everything is confidential. More encouraging were findings by Otto, Ogloff, and Small (1991) that more than 90% of their clinician respondents addressed the issue of confidentiality limits with their clients.

Impact of Confidentiality Information on Client Behavior

Do clients want to know the limits of confidentiality in therapy? Nearly all (96%) of the respondents in a study by Miller and Thelen (1986) indicated that they wanted to be informed of the limits of confidentiality, and close to half stated that they wanted to be given this information prior to the first session of therapy.

If clients are informed of the limits of confidentiality, what effect might it have on the treatment process? Research findings regarding the effect of the provision of confidentiality information on client disclosures have yielded mixed results. Several studies have indicated that information regarding confidentiality limits had no effect on participants' willingness to disclose personal information (e.g., Muehlman, Pickens, & Robinson, 1985; Haut & Muehlman, 1986). Findings from a study by Kobocow, McGuire and Blau (1983) indicated that even when assurances of absolute confidentiality were provided, participants disclosed the same degree of potentially stigmatizing information as participants who did not receive such assurances.

A number of studies in this area, however, seem to suggest that the provision of information about confidentiality limits does effect the degree to which people reveal personally relevant information. Woods and McNamara (1980) found that when interviewees were given information

that disclosures might not be completely confidential, they were less open than those interviewees who were told that material disclosed would be kept strictly confidential or those who were given no information regarding confidentiality. Similar findings have concurred that confidentiality information is an important factor in how self-disclosing clients will be in psychotherapy (Merluzzi & Brischetto, 1983; McGuire, Toal & Blau, 1985; VandeCreek, Miars & Herzog, 1987).

In a study of the effect of the provision of confidentiality information on client in-session behaviors, Taube and Elwork (1990) found that those individuals who were made aware of limits of confidentiality did not disclose as many child punishment and neglect behaviors, or as many socially unacceptable sexual thoughts and behaviors, as did individuals who were not informed of such limits. The authors hypothesized that self-disclosure about sensitive issues was determined by two factors: (1) how well the client understood laws regarding the therapist's duty to breach confidentiality in certain circumstances, and (2) how relevant and consequential the law was to that client.

When a client does disclose information about a "sensitive issue" such as child abuse, clinicians are faced with the difficult decision of whether to breach confidentiality and report the disclosure to an outside party. The following section addresses the limits of confidentiality

related to child abuse, and delineates variables that seem to influence the reporting behavior of clinicians.

Limits of Confidentiality Related to Child Abuse

Reporting Statutes

Over the last two decades, increasing attention has been paid to the problem of child abuse and neglect. According to DeAngelis (1990), 60,000 cases of child abuse and neglect were reported in 1974; that number jumped to 2.4 million in 1989. Estimates of the actual incidence of child abuse and neglect vary considerably; the majority of abused children go unidentified and unprotected, and later as adults are at greater risk for abusing their own children.

Currently, mandatory reporting legislation has been enacted in all 50 states and the District of Columbia. Reporting statutes require specified professionals to report suspected cases of child abuse to the appropriate authorities, most commonly a child protective service agency. Typically, child abuse reporting laws consist of (1) a definition of child abuse/maltreatment, (2) a categorical listing of who is mandated to report abuse, (3) a delineation of when, how, and to whom a report must be made, and (4) statements regarding provisions for immunity, and penalties for failure to report suspected abuse (Fraser, 1978; U.S. Department of Health and Human Services, 1989).

Since their inception, mandatory reporting of child abuse

statutes have met with considerable criticism. Critics of these statutes have questioned whether psychologists can fulfill their prescribed role as helping professional while concurrently acting as "double agent" who must disclose sensitive client information to the legal system (Stadler, 1989). Some clinicians have expressed concern that breached confidentiality has a detrimental effect on the therapeutic relationship, thus jeopardizing the potential for a positive resolution to family conflict and abuse (Zellman, 1990). Heyman (1986) contends that reporting laws do not give trained clinicians the opportunity to exercise their clinical judgement regarding the appropriateness or implications of reporting suspected abuse. Furthermore, clinicians have questioned the ability of child protective agencies to intervene effectively in abusive families (Finkelhor, Gomes-Schwartz, & Horowitz, 1984). These concerns influence the decision-making of clinicians who are faced with reporting decision, and will be explored further in the following sections.

Variables Influencing Clinicians' Reporting Decisions

Research on the reporting practices of psychologists have consistently indicated that a substantial proportion of practitioners choose not to report abuse when they become aware of it during the course of psychotherapy (e.g., Zellman, 1990; Nicolai & Scott, 1994; Saulsbury & Campbell, 1985).

Numerous factors appear to influence the likelihood of reporting suspected abuse.

The degree to which a clinician is confident that a child has been abused is a significant factor that influences reporting decisions (e.g., Nicolai & Scott, 1994; Kalichman et al., 1988; Finlayson & Koocher, 1991). The presence of clear, unequivocal indicators of abuse such as bruises and other physical signs are associated with higher degrees of reporting than are nonspecific clinical symptoms (Brosig & Kalichman, 1992; Kalichman & Brosig, 1992; Finlayson & Koocher, 1991). Verbal disclosures of abuse, by either the child or the abuser (particularly allegations of sexual abuse) are also strongly associated with clinicians' certainty of abuse and subsequent reporting (Finlayson & Koocher, 1991; Kalichman & Craig, 1991; Kalichman & Brosig, 1992; Zellman, 1992).

Other variables that influence reporting decisions include the age of the child suspected of being abused (Kalichman & Brosig, 1992), the ethnicity of the family (Newberger, 1983; Giovannoni, 1989), and specific types of abuse (Nightengale & Walker, 1986; Zellman, 1990). Furthermore, studies have indicated that how clinicians interpret the wording of reporting laws influences the likelihood that they will/will not report suspected abuse (Muehleman & Kimmons, 1981; Brosig & Kalichman, 1992; Kalichman & Brosig, 1992). Additionally, and most relevant to

the present study, is the finding by Nicolai and Scott (1994) that clinicians who typically (in their own practices) provide more frequent and specific information about confidentiality limits were more likely to report suspected abuse.

Clinicians' beliefs about the effect of reporting on treatment has had an impact on reporting decisions. Kalichman et al. (1989) found that 42% of psychologists in their study believed that reporting suspected child abuse has an adverse effect on the treatment process. In related study, one third of practitioners who had reported suspected child abuse subjectively felt that their report was detrimental to therapy (Kalichman & Craig, 1991). However, systematic studies of the actual effect of reporting on the therapeutic process have suggested that reporting suspected abuse does not adversely affect ratings of therapist-client relationships or client drop-out rates (e.g., Watson & Levine, 1989). Thus, although practitioners may be reluctant to report suspected child abuse because of fears related to potential negative consequences on treatment, there does not seem to be clear objective evidence that these fears are warranted.

The Effect of Informing Clients of Confidentiality Limits on Reporting Behavior

In the therapeutic relationship, the clinician clearly holds the expert role. Regarding the expectations and "rules" of therapeutic interactions, the clinician acts as purveyor of

information that may well be new to the client. In other words, it is the therapist's responsibility to "set the stage" for the client. This responsibility is fundamental to the very nature of the profession, as safeguarding the welfare of clients is perhaps the central dictum by which clinicians practice (APA, 1992).

Confidentiality is one of the most crucial aspects of the therapeutic relationship. Thus, it is incumbent upon the clinician, in his/her role as expert and knowledgeable purveyor of information, to communicate to the client circumstances under which information disclosed in therapy will not be held in confidence. A client's disclosure of behavior that potentially invokes mandatory reporting requirements results in the clinician having to decide whether to breach confidentiality and inform an outside party. Research and anecdotal evidence clearly indicate that clinicians experience marked ambivalence and discomfort when faced with this decision (Kalichman, 1993).

A team of researchers headed by Dr. Murray Levine at SUNY-Buffalo conducted a series of studies that add to our understanding of the experiences of clinicians who are faced with the myriad dilemmas in reporting suspected child abuse. One of these studies (Levine, Anderson, Ferretti, Sharma, Steinberg & Wallach, 1992) is particularly relevant to the present discussion. Thirty psychotherapists who had made

recent child abuse reports were interviewed in order to identify common themes in their experiences. In particular, these clinicians were asked about their views and practices regarding informing clients of the limits of confidentiality, specifically around issues of reporting child abuse.

The Levine et al. (1992) findings shed light on how two significant therapist actions -- informing clients of limits and reporting decisions -- might be linked. The authors state that "If a therapist has failed to inform a client of limits, or has promised confidentiality and then the client discloses [information that the therapist is mandated to report], the therapist may suffer pangs of guilt" (p. 9). This statement is followed by a quote from one therapist whose client disclosed that she had been sexually abused: "I felt really awful because I had said to her that I would keep what she says in confidence. Thank heaven for colleagues because they all came in and said to me that I had to call this in" (p. 9). In this case, the therapist seems to be articulating that his/her feelings of guilt about "deceiving" the client (due to a failure to inform the client of confidentiality limits) resulted in significant discomfort about a subsequent -- legally mandated -- breach of confidentiality.

This particular piece of qualitative data raises an interesting question: Does a clinician's behavior regarding informing (or not informing) clients of confidentiality limits

produce differential subjective experiences that in turn influence the likelihood that clinician will (or will not) decide to report suspected child maltreatment or abuse?

Consider the following case: Dr. A., a psychologist working in a community mental health center, is conducting an intake interview with "John," a male client who is seeking help for depression. During the course of the interview, John discloses information that suggests he might be abusing his 10-year-old son. Consistent with his/her legal obligations, Dr. A. must decide whether he/she should report John to Child Protective Services.

The previous discussion of factors that influence the reporting decisions of clinicians suggests that Dr. A. will consider various aspects of the case when making this decision, including the perceived severity of abuse. It is also likely that Dr. A. will experience some discomfort when contemplating the effect that reporting will have on treatment. As discussed earlier, many psychologists fear that breaching confidentiality -- even when clients understand that clinicians are legally obliged to do so in cases of suspected child abuse -- will result in irreparable damage to the therapeutic relationship, or in the client terminating services prematurely. These concerns will also influence Dr. A.'s reporting decision.

Now consider the experiences of the therapist who

provided inaccurate information regarding confidentiality (i.e., that everything disclosed would be held in confidence) to his/her client in the previously cited Levine et al. (1992) study. This clinician indicated that his/her discomfort resulted in hesitancy to report the abuse. It seems reasonable to hypothesize that when clinicians do not provide accurate or complete information about confidentiality limits to clients who later disclose information that is legally reportable, these clinicians might experience increased discomfort regarding reporting decisions because they perceive the increased potential for harm to the client and the therapeutic relationship. Specifically, it is hypothesized that not providing clients with confidentiality information magnifies the concerns already present regarding the impact of breaching confidentiality on treatment. Additionally, concerns that the client will feel "deceived" by the therapist, and that the therapist will no longer be perceived as a trustworthy helper will be magnified.

The notion that people experience discomfort when they have done (or failed to do) something that is associated with negative consequences, and that this discomfort can lead to attitude or behavior change, is not a new one. Social psychologists have studied this phenomenon, called cognitive dissonance, for over three decades. The following discussion explores the potential explanatory power of cognitive

dissonance theory as a framework for understanding the link between informing clients of confidentiality limits and reporting child abuse.

Cognitive Dissonance Theory as an Explanatory Framework

Cognitive dissonance theory, as it was originally proposed by Festinger in 1957, held that dissonance -- a general state of psychological discomfort -- occurs when a person holds two cognitions that are inconsistent. He further proposed that people are motivated to reduce this dissonance, and that these efforts often result in attitude and/or behavior change. In one test of the theory, Festinger and Carlsmith (1959) asked their student subjects to tell a fellow student that a very boring task was actually very exciting. The investigators hypothesized that the inconsistency between the cognitions "I know the task is really boring" and "I told my fellow student that the task is very exciting" would arouse dissonance in the subjects, which in turn would lead to the subjects' changing their attitudes about the task. Festinger and Carlsmith found that subjects did, in fact, rate the task as more positive following the manipulation.

In subsequent studies introducing the induced compliance paradigm, subjects were offered monetary incentives to make counterattitudinal statements. Festinger and Carlsmith (1959) predicted that incentives would allow subjects to justify

their counterattitudinal behavior and experience less dissonance, and again their hypothesis was supported. In a review of cognitive dissonance research utilizing the induced compliance paradigm, Worchel, Cooper, and Goethels (1988) concluded that dissonance is aroused and attitude change can occur when people (1) expect that their behavior is, was, or will be associated with an aversive or unpleasant consequence, (2) perceive that their behavior is irrevocable (i.e., cannot be "undone"), and (3) perceive that they have the freedom of choice and are responsible for engaging in a behavior.

Each of these conditions -- the occurrence of an aversive event as a result of a behavior, the perception of choice regarding a behavior, and the irrevocability of the behavior-- will be considered individually as they relate to informing clients of confidentiality limits and subsequent decisions regarding reporting child maltreatment/abuse. In other words, the following paragraphs will attempt to answer the question, "do the central features of cognitive dissonance fit the experiences of clinicians who fail to inform clients of confidentiality limits and then are faced with reporting decisions?"

Aversive Consequences

The first condition articulated by the cognitive dissonance model is the occurrence, or the perception of the occurrence, of an aversive or unpleasant event. Cooper,

Zanna, and Goethels (1974) designed a study to test their hypothesis that rather than inconsistency among cognitions per se, the crucial factor in dissonance arousal and attitude change is the production of an unwanted or aversive event. After manipulating subjects to either like or dislike a fellow student (who was actually a confederate), these investigators had subjects try to convince the confederate student that a boring task was actually exciting. Half of the liked and half of the disliked confederates indicated that they were convinced, and half indicated that they were not convinced that the task was actually exciting. The only subjects who changed their attitudes about the task were those who believed that they had "convinced" a liked fellow student that the boring task was exciting (an unpleasant outcome). Subjects who "convinced" a disliked student did not show attitude change, presumably because the outcome was not perceived to be unpleasant or negative. Cooper and Fazio (1984) point out that it is not the actual occurrence of an unwanted event -- but only the perception or expectation of an unwanted event -- that is central to dissonance arousal and attitude change.

Does this component of dissonance theory "fit" the experiences of clinicians in regard to informing clients of limits and making reporting decisions? Most clinicians will agree that making decisions about whether to report suspected child abuse is an aversive experience. This decision-making

process is both professionally and personally challenging because breaching confidentiality in order to report abuse raises concerns about potential breakdowns in the treatment process and in the therapeutic relationship, and may subject clinicians to professional scrutiny, civil liability actions, and vindictive reactions from clients.

It is hypothesized that adding to the potential negative consequences of reporting abuse is the perceived adverse effects of the clinician "betraying" the confidences of the client when the clinician has failed to inform the client of limits. It is hypothesized that in this particular series of events, clinicians are more likely to consider the possibility that they have "erred" by not informing their client of confidentiality limits. Perhaps, for example, the client interpreted the absence of such information as an "implicit commitment" to confidentiality, and would not have disclosed self-incriminating information if he/she had been aware of the therapist's mandatory reporting obligations (recall the findings of Taube and Elwork, 1990, regarding clients' disclosures of sensitive information).

It is hypothesized that clinicians experience dissonance when they realize, subsequent to a client's disclosure of reportable material, that their failure to provide information about confidentiality limits might have constituted an implied commitment to absolute confidentiality. This dissonance is

hypothesized to take the form of "guilty" feelings (Levine et al., 1992) that they have deceived their client, and/or have not acted in a professional and ethical manner toward their client regarding the provision of information about confidentiality limits.

Irrevocable Action -- Irrevocable Consequences

The perception that an action resulting in an unwanted event is irrevocable is also central to dissonance arousal and attitude change. If the action can be reversed, done over, or "taken back" somehow, dissonance arousal will not occur. For instance, if the subjects in the Cooper et al. (1974) study cited earlier were given the opportunity to "come clean" to the liked fellow students about the true nature of the task, they would not experience dissonance arousal or attitude change. In a study by Davis and Jones (1960), subjects were induced to make negative, counterattitudinal statements about a fellow student. Half of the subjects believed that they would have the opportunity to tell the fellow student that the statements had been made as part of a psychology experiment, and half were not told that they could "take back" their statements in this way. Results of this study indicated that the only subjects who showed attitude change (i.e., rated the fellow student more negatively) were those who believed that their statements, and the consequences of their statements, were irrevocable.

The issue of whether or not clients have been informed of confidentiality limits is brought into sharp relief when they disclose information that legally mandates a clinician to breach confidentiality. The behavior of informing or not informing clients of confidentiality limits is clearly irrevocable at that point. And although some therapists have informed their clients of limits retroactively -- that is, after the clients have incriminated themselves -- the provision of information in this manner makes a pretense of the informed consent procedure.

Perception of Choice

The third component articulated by the cognitive dissonance model that is necessary for the arousal of dissonance is the perception that the behavior was freely chosen. Research findings consistently indicate that subjects experience dissonance and change their attitudes only under conditions of perceived high choice (e.g., Davis & Jones, 1960; Cooper & Brehm, 1971; Collins & Hoyt, 1972).

Clinicians are free to choose whether they will or will not inform clients of confidentiality limits. Although ethical guidelines assert that such information should be provided to clients at the outset of therapy, the clinician is allowed to use his/her judgement regarding whether the provision of this information is in the best interests of the client. Except in federally funded alcohol and substance

abuse treatment programs, clinicians are not legally mandated to provide information on the limits of confidentiality to clients. Thus, the clinician is free to provide this information, or is free not to provide it. The condition of a perception of choice regarding informing clients of confidentiality limits is therefore met.

In summary, it appears that the conditions articulated by cognitive dissonance theory for the arousal of dissonance are met when clinicians' reporting decisions are considered in the context of whether clinicians have (or have not) informed their clients of confidentiality limits regarding suspected child maltreatment/abuse. Clinicians who fail to inform their clients of confidentiality limits (a freely chosen, irrevocable behavior), and whose client subsequently discloses reportable information will anticipate the potential adverse effects of their behavior on a "betrayed" client, harm to the therapeutic relationship, and damaged identities as ethical professionals (unpleasant consequences).

Upon acceptance of the relevance of the cognitive dissonance framework to the question under examination, the next step is to articulate specific hypotheses that follow from the theoretical model. The central hypotheses of the present study are best presented within the context of cognitive dissonance theory's predictions about the strategies that people use to reduce the dissonance that they experience

under the conditions previously articulated.

Strategies for Reducing Dissonance

Festinger (1957) asserted that changing one's attitude or behavior to "fit" better with the discrepant behavior or cognition is only one way that people reduce dissonance. For instance, people can discredit or devalue the information that resulted in dissonance, they can discredit or devalue the source of the information, and they can add cognitions in order to "justify" their original cognition or behavior. All of these strategies result in a reduction of discomfort or dissonance.

The following paragraphs will enumerate hypothesized strategies that clinicians use in order to reduce dissonance associated with their failure to provide information regarding confidentiality limits to clients in therapy. These strategies include (1) minimization or distortion of client disclosures of abuse; (2) assumption that the client did or did not understand confidentiality limits, and (3) justification of the failure to provide confidentiality information.

Minimization or Distortion of Client Disclosures of Abuse

First, it was hypothesized that psychologists who experience dissonance due to their failure to inform clients of limits might reduce their discomfort by minimizing or distorting the incriminating information disclosed by the

client. For example, they could decide that the available evidence does not warrant a "reasonable suspicion" of abuse, and be less certain that abuse has actually occurred. Thus, clinicians could circumvent unpleasant consequences to themselves, their client, and the therapeutic relationship by deciding that reporting statutes are not clearly applicable.

Moreover, it was predicted that the relation between dissonance and certainty of abuse would hold only in cases where the presence of abuse is somewhat ambiguous, such as suspected abuse that is perceived to be less serious (e.g., spanking a child resulting in possible marks or bruises). It was hypothesized that in these more ambiguous cases, dissonance associated with the failure to provide information about confidentiality limits will be very salient, and minimizing the abuse will be a potentially acceptable (though very likely not conscious) dissonance reduction strategy.

On the other hand, if the abuse was severe, or if the evidence for it was incontrovertible, it was hypothesized that clinicians would not reduce their dissonance by distorting information disclosed to them by the client. For example, a client's disclosure that he is molesting his daughter is clearly severe abuse that invokes mandatory reporting laws. In this case, whether or not the clinician has informed the client of limits takes on much less significance in light of the seriousness of the abuse, and so any dissonance associated

with a failure to inform the client of limits will not result in minimization of the abuse (or decreased reporting).

Assumption of Client Understanding Confidentiality Limits

Clinicians who experience discomfort as a result of the failure to provide information regarding confidentiality limits to clients, and who are subsequently faced with a reporting decision, could choose to report or not to report the situation to Child Protective Services. It was expected that regardless of the reporting decision made, dissonance arousal occurs in these situations and that higher levels of dissonance are associated with perceptions that the client was not aware of confidentiality limits.

However, it was hypothesized that compared to those who chose not to report the situation, those who decided to breach confidentiality and report the abuse could reduce dissonance by deciding that their client really did understand the limits of confidentiality, even though the client was never provided this information explicitly. There is some evidence to support the notion that clinicians overestimate the degree to which clients are generally aware of the limits of confidentiality in therapy (Brosig, 1992, cited in Kalichman, 1993); it is conceivable that a clinician's estimation of a client's knowledge could change as a function of the clinician's own dissonance regarding a failure to inform, particularly when the clinician chooses to breach

confidentiality.

Justification of the Failure to Provide Confidentiality
Information

Finally, clinicians who experience dissonance as a result of the failure to inform clients of limits might seek to justify this failure to a greater extent than clinicians who do not experience this dissonance. Specifically, a clinician who does not inform his/her client of confidentiality limits and who is faced with a reporting decision might be more likely to "believe" that CPS intervention is unnecessary in the case, or that CPS intervention would be ineffective or even harmful. In this way, the clinician would be able to reduce his/her dissonance associated with the failure to inform the client of limits by asserting that breaching confidentiality in order to report is not a favorable response to the client's incriminating disclosure. For example, dissonance could be reduced by asserting that "It's okay that I didn't inform the client of potential breaches of confidentiality because such a breach in this case would result in irreparable damage to the therapeutic relationship."

Therefore, it was expected that dissonance associated with the failure to inform clients of confidentiality limits would be associated with justifications such as the belief that (a) reporting the case to CPS would adversely affect the client's treatment, (b) reporting the case to CPS would

jeopardize the safety of the client's child, and/or (c) the case could be handled more effectively without CPS intervention.

Furthermore, because there is evidence that these beliefs are related to reporting decisions (e.g., potential damage to the therapeutic relationship is related to nonreporting: Kalichman et al., 1989) the justification variables were conceptualized as indirect measures of reporting tendency.

Summary of Hypotheses

A model of the primary hypotheses of the present study is provided in Figure 1 (low abuse severity conditions) and Figure 2 (high abuse severity conditions).

In order to understand the causal models depicted, two terms must be defined. An exogenous variable is one whose variability is not examined because it is assumed to be determined by factors not included in the causal model (Pedhazur, 1982). In the hypothesized model, the exogenous variable is whether the clinician informed his/her client of confidentiality limits; variance in this exogenous variable is entirely a function of the inform/no inform manipulation. Alternatively, variation in the endogenous variables -- those on the "inside" of the model -- is assumed to be explained by exogenous and other endogenous variables in the model. In the hypothesized model, all the constructs of interest including Dissonance, Certainty of Abuse, Reporting Tendency, the three

CPS variables (CPS-Robert, CPS-Steven, and CPS-Unnecessary), and the Client Awareness variable are the endogenous variables.

At the far left of each figure is a symbol labeled "Confidentiality Information Provision." This symbol represents the manipulated exogenous variable pertaining to whether the clinician depicted in the vignette provided information about confidentiality limits to the client. Confidentiality Information Provision (inform/no inform) was treated as the sole exogenous variable in each of the two submodels. (Note: Although abuse severity could also be considered an exogenous variable, the severity manipulation was addressed by proposing distinct high and low severity submodels).

To the right of "Confidentiality Information Provision" are two other construct symbols, labeled "Dissonance" and "Certainty of Abuse." These symbols represent the endogenous predictor variables in the model. Finally, at the far right of each figure are symbols that represent the four endogenous criterion variables in the hypothesized model: Reporting Tendency, three justification variables labeled CPS-Robert (perceived adverse effects on Robert's treatment as a result of CPS intervention), CPS-Steven (perceived risk to the client's son Steven as a result of CPS intervention), and CPS-Unnecessary (belief that the case could best be handled

without CPS intervention), and Client Awareness (extent to which Robert was aware of the limits of confidentiality).

The measurement of specific variables (e.g., dissonance, certainty of abuse, and dissonance reduction strategies) are addressed in the Method section.

Hypotheses for Low Severity of Abuse Condition

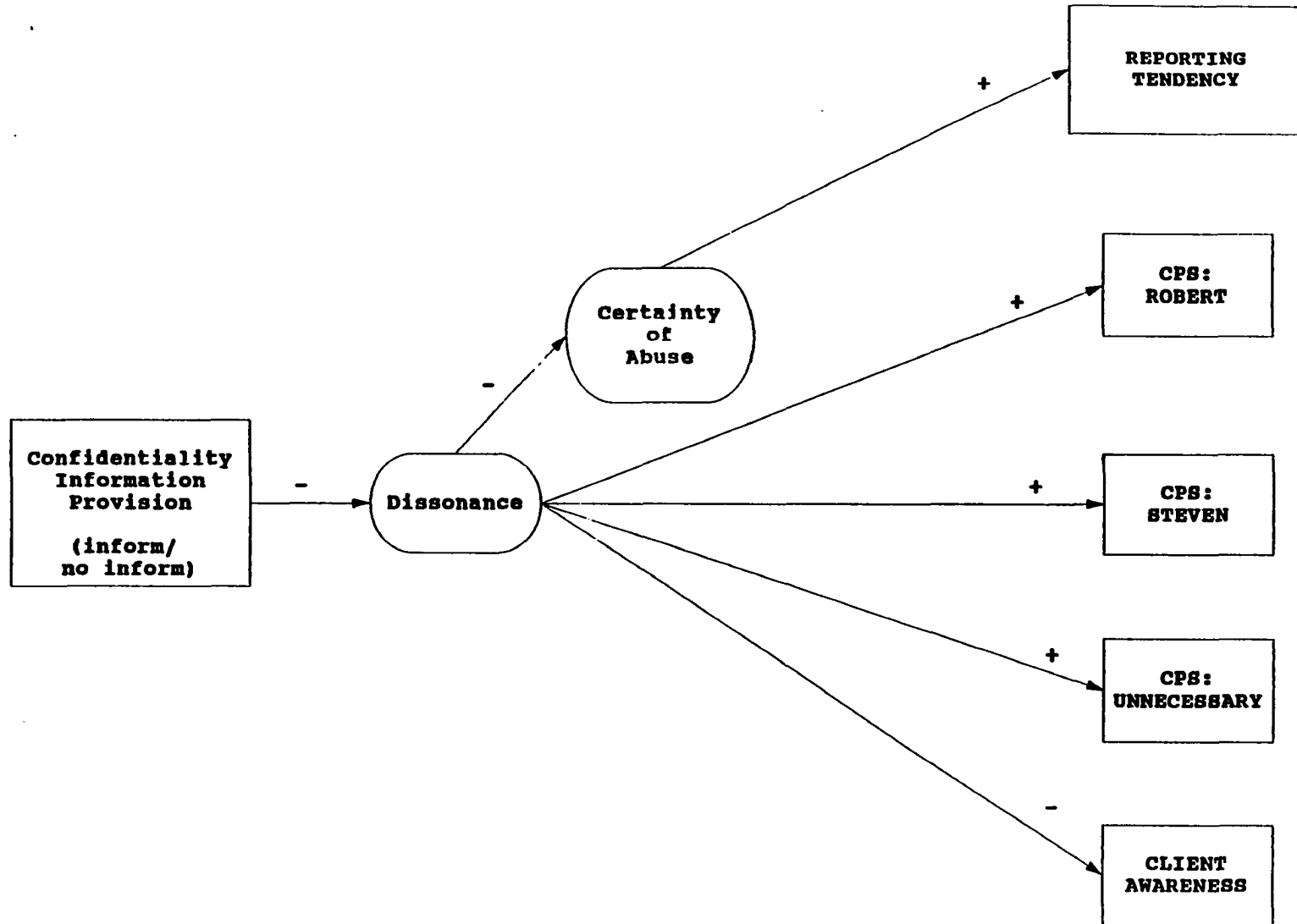
Figure 1 depicts hypotheses regarding expected effects of informing/not informing clients of limits in conditions of low abuse severity. It was expected that failure to inform clients of limits in such cases would result in dissonance. It was expected that dissonance would decrease clinicians' certainty that abuse had occurred (Certainty), which in turn would result in lower reporting scores (Reporting Tendency).

Further, it was hypothesized that clinicians might utilize other dissonance reduction strategies. Specifically, it was expected that clinicians would seek to justify their failure to inform clients of limits by (a) indicating that CPS intervention was unnecessary (CPS-Unnecessary), or would be detrimental in some way (CPS-Robert or CPS-Steven) and/or (b) changing their perceptions of whether the client actually understood confidentiality limits (Client Awareness).

Hypotheses for High Severity of Abuse Condition

Figure 2 depicts hypotheses regarding expected effects of informing/not informing clients of limits in conditions of high severity of abuse. Similar to the predictions in the low

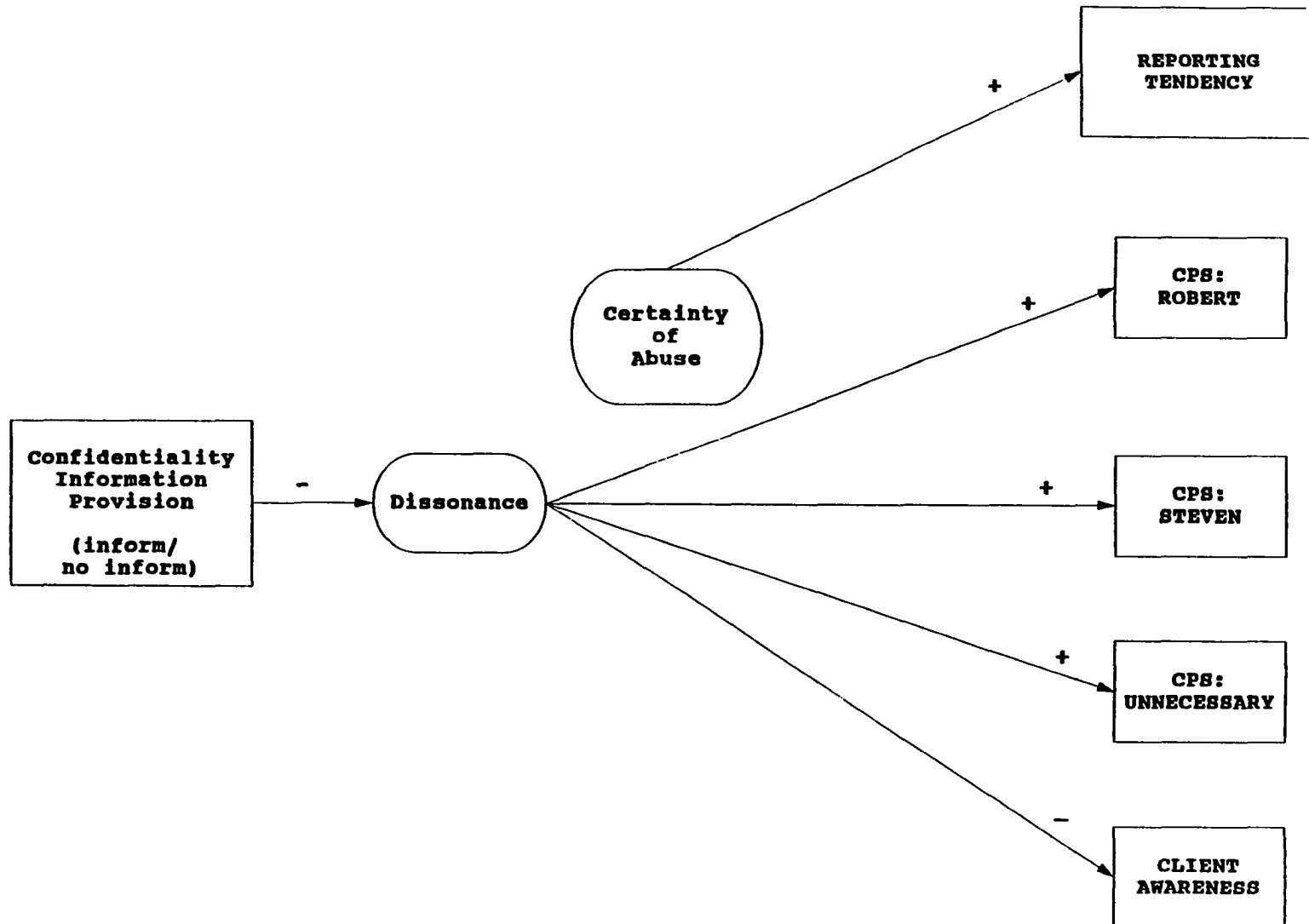
Figure 1: Hypothesized relations among model constructs in the low severity conditions



abuse severity conditions, it was expected that failure to inform clients of limits in severe abuse cases would result in dissonance. Unlike expectations in the low abuse severity condition, it was hypothesized that dissonance would not result in changes in perceived abuse certainty or affect subsequent reporting behavior in the high severity condition for reasons articulated earlier in this paper (p 28). Rather, it was hypothesized that reporting behavior would be driven only by certainty of abuse, which was expected to be quite high.

It was further hypothesized that in the high severity condition, dissonance experienced by clinicians who did not inform their clients of confidentiality limits would be reduced primarily through the use of alternative dissonance reduction strategies (the three CPS-related variables and Client Awareness) depicted in Figure 2.

Figure 2: Hypothesized relations among model constructs in the high severity conditions



METHOD

Participants

Three states whose mandatory reporting of child abuse statutes met two criteria were identified. The first criteria was that the statute must have specified that either mental health professionals or psychologists were mandatory reporters of child abuse. Second, the statute must have neither stated nor implied that the child must be a client of or be seen by the practitioner to invoke mandatory reporting requirements.

Arkansas, Connecticut and New Mexico met both criteria (U.S. Department of Health and Human Services, 1989). Mailing lists of licensed psychologists from the state licensing boards of Arkansas, Connecticut, and New Mexico were secured. Six hundred (600) participants from the three identified states were randomly selected. The number of names selected from any one state's mailing list reflected the proportion of psychologists representing that state to the total number of psychologists in all three states. Thus, after calculating the number of psychologists from each state to be surveyed, every *n*th (e.g., third, fifth, etc.) name on the list was identified as a study participant.

Materials

A 27-item survey was designed to gather information on variables related to informing clients of the limits of confidentiality and reporting child abuse (see Appendix B).

Included in the survey was a case vignette that depicted a conversation between Dr.H. and Robert, a client who discloses that he has potentially abused his son. In the vignette, both the provision of confidentiality information presented by the clinician and the severity of abuse alluded to by the client were manipulated (see Appendix B).

The information provision manipulation consisted of a statement telling respondents that Dr. H. either had informed Robert of the limits of confidentiality (conditions one and three: "inform") or had not informed Robert of the limits of confidentiality (conditions two and four: "no inform").

The severity of abuse depicted in the vignette was also manipulated. In conditions one and two, the abuse was described as possible bruises on the child's buttocks as a result of being "whipped" by the client ("low severity"). In conditions three and four, the child was also depicted as having a black eye ("high severity").

Thus, one of four vignettes (inform/low severity, no inform/low severity, inform/high severity, no inform/high severity) was presented to the psychologists surveyed. Participants were asked to put themselves in the place of Dr. H. and respond to a number of items related to the vignette. All items (described below) were anchored on 6-point Likert scales.

The vignettes were submitted to an informal pilot test

with six clinicians who worked in a child and family guidance center. Ratings of plausibility/believability were obtained from the raters. These ratings indicated that the vignettes were perceived as realistic depictions of a clinical situation involving the disclosure of child abuse by an adult client.

The first group of items following the vignette (Appendix B, items 1-6) were introduced with the direction for respondents to imagine that they were Dr. H. and rate the degree to which they agreed with statements designed to measure discomfort associated with "their" behavior regarding informing Robert of confidentiality limits. These items included statements regarding respondents' perceptions of the ethicality of their behavior, of the potential harm to the therapeutic relationship as a result of their behavior, of the "deceptive" nature of their behavior, and feelings of guilt and discomfort. Collectively, this group of items comprised the measure of dissonance.

Items 7 and 8 related to how likely respondents would be to report the case to Child Protective Services, and how comfortable they would be with their reporting decision.

The next three items (Appendix B, items 9-11) were designed to measure respondents' perception of Robert's behavior and certainty that abuse had occurred based on the information presented. These three items constituted the measure of certainty.

The next group of three items directly related to the vignette (items 12-15) were designed to assess respondents' attempts to reduce dissonance by justifying their failure to provide confidentiality information (by indicating that CPS intervention would adversely affect the client's treatment, would jeopardize the safety of the client's child, or was not necessary) and to serve as indirect measures of reporting tendency (as compared to the direct measure, item 7).

The fourth item asked respondents to rate the degree to which they believed that the client understood the limits of confidentiality. This item (item 15) served as both a dissonance reduction strategy and a manipulation check on the information provision manipulation.

The last set of items (items 16-27) gathered descriptive and demographic information from respondents, including their sex, years of experience, theoretical orientation, and work setting. Respondents were also asked to indicate (a) how frequently and specifically they inform clients of confidentiality limits, and (b) the number of incidents of abuse they had suspected and reported in the previous three years.

Procedure

Packets containing a cover letter and response card (Appendix A), a survey (Appendix B), and stamped return envelope were mailed to identified participants. Completed

surveys and response cards were returned by mail separately to the principal investigator. This procedure preserved the anonymity of respondents and allowed for the identification of nonrespondents. A second survey packet was sent to nonrespondents approximately four weeks after the initial mailing.

Analyses

Analyses occurred in several stages and can be described according to the questions addressed in each stage. First, descriptive statistics, primarily frequencies and means, were calculated in order to address the question, "What were the demographic and practice characteristics of this sample of clinicians?"

Next, several sets of preliminary analyses were conducted in order to set the stage for the test of the proposed model of the relation of confidentiality information provision to reporting decisions. Using items designed as manipulation checks (Appendix B, items 10 and 15), analyses of variance were conducted to ascertain whether the conditions were effective. Reliability analyses, including item-total correlations and measures of internal consistency, examined the efficiency of items that collectively comprised scales of dissonance, abuse certainty, and reporting justifications related to CPS intervention.

The question, "Did the conditions affect the dependent

variables in the model?" was addressed via multiple analyses of variance. Specifically, constructs in the model including Dissonance, Certainty of Abuse, Reporting Tendency, the three CPS variables, and the Client Awareness variable were submitted to two-way (confidentiality information provision x abuse severity) analyses of variance.

Additionally, because previous research has found that certain demographic and practice characteristics of clinicians influence reporting behavior, each dependent variable of interest in this study was regressed on the set of potentially relevant demographic/practice characteristics. In addition to answering the question, "Were respondent characteristics related to the constructs of interest?" these analyses also explored whether respondent characteristics were differentially related to the dependent variables in the low severity vs. the high severity abuse conditions.

Next, the question "Were the relations among the dependent variables consistent with the proposed model of reporting decisions?" was addressed. Representing the primary stage of analyses in this study, the strategy used to examine this question is described in greater detail below.

Hypotheses regarding the predicted relations among constructs in the proposed model were examined via path analysis, or structural equation modeling. Pedhazur (1982) states that "path analysis is not a method for discovering

causes, but a method applied to a causal model formulated by the researcher on the basis of knowledge and theoretical considerations" (p. 580).

Path analysis is a method that relies on solving multiple regression equations posed by the researcher that are assumed to "fit" a particular theoretical model of causal relationships among variables. Standardized beta weights are determined for each hypothesized causal pathway that indicate the effect of one variable on another.

The hypothesized model, called the "reduced model" in path analytic terms, is tested for its goodness-of-fit by comparing it to a fully recursive model in which all possible pathways are tested. If the reduced model explains the variance in the data as well as the recursive model, then the reduced model is accepted as potentially valid.

In this study, the independent exogenous variables were severity of abuse (high/low) and the provision of information regarding confidentiality limits (inform/no inform). The first endogenous predictor variable in the model was dissonance. Dissonance, in turn, was expected to predict certainty of abuse, the three CPS variables, and client awareness of confidentiality information in the low severity abuse condition, and only the latter four variables in the high severity condition. Certainty of abuse was expected to predict reporting tendency in both the high and the low

severity conditions.

Finally, additional analyses related to the model were conducted. First, the use of Client Awareness as a dissonance reduction strategy was examined. Second, the question, "Was dissonance related to how comfortable respondents were in making their reporting decisions?" was addressed via correlational analyses.

RESULTS

Response Rate and Characteristics of Data Set

Of the 600 surveys that were originally mailed, one survey was received return-to-sender, and eight were returned uncompleted with notes indicating the inapplicability of the survey to the addressee. A total of 248 completed, interpretable surveys were returned, yielding an overall response rate of 42.0%. Return rates from each of the three states were as follows: Arkansas, 41.7% (50); Connecticut, 35.5% (127), and New Mexico, 48.5% (63). A chi-square test performed on the unequal expected frequencies of response rates for the three states was not significant, $X^2(n=240, 2)=1.75$, $p>.10$.

In regard to characteristics of the data set itself, Arkansas, Connecticut, and New Mexico respondents represented 20.8%, 52.9%, and 26.3% respectively, of the total sample (see Table 1).

The proportion of surveys returned in each of the four conditions were as follows: condition one (low severity/inform): 25.8% (64); condition two (low severity/no inform): 21.0% (52); condition three (high severity/inform): 23.4% (58), and condition four (high severity/no inform): 29.8% (74). A chi-square test of independence performed on the four conditions revealed that return rates did not differ significantly between conditions, $X^2(3, n=248)=4.26$, $p>.10$.

Demographic Characteristics of Respondents

Demographic characteristics of the respondents are presented in Table 1. One hundred forty-four (58.5%) respondents were male and 102 (41.5%) were female. The majority of respondents held a Ph.D. in psychology (227; 91.5%). They reported a range of clinical experience, from one year to 50 years, with an average of 16.7 years of experience.

Furthermore, Table 1 shows that respondents represented diverse theoretical orientations. The four most frequently reported orientations were eclectic (72; 29.3%), psychodynamic (58; 23.6%), cognitive (48; 19.5%), and behavioral (23; 9.3%).

The majority of respondents worked in private/group practice settings (151, 61.4%), and the others (95, 38.6%) worked in other settings including community mental health centers, family guidance centers, and psychiatric medical centers.

Practice Characteristics Relevant to Study

Respondents were asked to provide other information about their own clinical practices that related directly to the questions under investigation. Specifically, they were directed to estimate the frequency with which they personally provided information about confidentiality limits to their therapy clients (see Appendix B, item 24). Table 2 indicates that whereas 35.1% (86) of respondents indicated that they "always" provided this information and 32.2% (79) "usually"

Table 1

Demographic Characteristics of Respondents

<u>Variable</u>	<u>N</u>	<u>(%)</u>
Sex		
Male	144	(58.5)
Female	102	(41.5)
Degree		
Ph.D.	227	(91.5)
Ed.D.	8	(3.2)
Psy.D.	12	(4.8)
Years of Experience		
Range = 1 - 50 years, <u>M</u> = 16.7 years		
State		
Arkansas	50	(20.8)
Connecticut	127	(52.9)
New Mexico	63	(26.3)
Theoretical Orientation		
Behavioral	23	(9.3)
Cognitive	48	(19.5)
Eclectic	72	(29.3)
Humanistic	14	(5.7)
Psychodynamic	58	(23.6)
Systems/Family	18	(7.3)
Other	13	(5.3)
Practice Setting		
CMHC	20	(8.1)
General medical center	5	(2.0)
Psychiatric medical center	11	(4.5)
Private/group practice	151	(61.4)
Family guidance center	9	(3.7)
University counseling center	5	(2.0)
Forensic/correctional facility	3	(1.2)
VA medical center	7	(2.8)
Other	35	(14.2)

did, nearly a third of respondents said they "sometimes" (19%, 47), "rarely" (12.5%, 31), or "never" (.8%, 2) provided information regarding confidentiality limits to clients. These findings are consistent with those of Nicolai and Scott (1994), who also found that, contrary to APA ethical guidelines, many clinicians are less than diligent in terms of consistently informing clients of confidentiality limits.

Additionally, respondents estimated how frequently their agency provided information regarding confidentiality to clients (Appendix B, item 23). The mean scores on items regarding the personal provision of information and agency provision of information were equivalent ($M=3.88$ and 3.83 , respectively), suggesting that confidentiality information is, on average, "sometimes" to "usually" provided to therapy clients by both the practitioners as well as their agencies.

A related question concerned the type or specificity of confidentiality information that was typically provided to clients (Appendix B, item 26). Table 2 shows that most practitioners told clients that there were specific circumstances under which confidentiality might be breached (215, 91.5%), including suspected child abuse, and threatened harm to self and others.

Another set of questions concerned practitioners' reporting histories. Respondents were asked to estimate, over the last three years, how many times they had suspected child

Table 2

Practice Characteristics of Respondents

<u>Variable</u>	<u>N</u>	<u>(%)</u>
Confidentiality Information Provision: Self		
Always provide information	86	(35.1)
Usually provide information	79	(32.2)
Sometimes provide information	47	(19.2)
Rarely provide information	31	(12.7)
Never provide information	2	(.8)
Confidentiality Information Provision: Agency		
Always provide information	80	(36.9)
Usually provide information	65	(30.0)
Sometimes provide information	37	(17.1)
Rarely provide information	24	(11.1)
Never provide information	11	(5.1)
Specificity of Confidentiality Information Provided		
Everything confidential ^a	3	(1.3)
Nonspecific information ^b	18	(7.6)
Specific information ^c	215	(91.5)
Child Abuse Reporting History		
Nonsuspectors	97	(39.1)
Consistent reporters	88	(35.5)
Inconsistent reporters	63	(25.4)

^a Clients are told that everything is confidential

^b Clients are told that there may be limits to confidentiality (without specifying what those limits might be)

^c Clients are told that confidentiality might be breached in specific circumstances (e.g., threatened harm to self or other, suspected child abuse, etc.)

abuse as well as how many times they had reported suspected abuse (see Appendix B, items 26a and 26b respectively). Respondents suspected from 0 to over 99 incidents of abuse in the last three years, resulting in an average of 4.0 suspected incidents per respondent for the entire sample. Furthermore, respondents reported an average of 3.3 cases of suspected child abuse in the prior three years.

Most relevant to this study was the comparison between the number of suspected incidents and the number of reported incidents of abuse. Respondents who said they had not suspected or reported child abuse in the last three years were labeled "nonsuspectors" in Table 2, and comprised 39.1% (97) of the sample of clinicians. Those who reported the same number of suspected incidents were labeled "consistent reporters" (88, 35.5%) whereas those who suspected more incidents than they reported were labeled "inconsistent reporters" (63, 25.4%) in Table 2. The finding that over one-quarter of the clinicians surveyed had not reported a suspected case of child abuse on at least one occasion is consistent with previous research on the reporting histories of clinicians (Nicolai & Scott, 1994; Zellman, 1990; Saulsbury & Campbell, 1985).

Preliminary Analyses

Several sets of preliminary analyses were conducted and each set will be addressed in its own subsection. These sets

of analyses involved (1) manipulation checks on perceived abuse severity and perceived client awareness of confidentiality limits; (2) reliabilities of multi-item dependent variables; (3) differences in the dependent variables among the four conditions, and (4) the relation of demographic and practice characteristics to the dependent variables.

Manipulation Checks

Abuse severity. The survey item, "How would you describe Robert's behavior toward his son?" (Appendix B, item 10), served as a manipulation check for perceived severity of abuse described in the clinical vignette. A 2 x 2 analysis of variance (severity x information provision) performed on the perceived abuse severity item yielded a significant main effect for severity, $F(1,233) = 44.25$, $p < .0001$, $d = .90$. The mean rating on this item was 3.23 in the low severity conditions and 3.97 in the high severity conditions.

Respondents perceived less severe abuse in the low severity conditions (describing a whipping) compared to the high severity conditions (describing a whipping and a black eye). However, the mean responses on this item for both the low severity and the high severity conditions fell between the "Moderately abusive" and "Quite abusive" scale anchors. Thus, although respondents perceived differences in severity between the conditions as expected, the perceived qualitative

differences between conditions could be interpreted as modest.

No main effect for the information provision conditions, $F(1,223)=p>.10$, $d=.09$, nor any interaction between severity and information provision, $F(1,243)=1.22$, $p>.10$, $d=.14$, were found.

Confidentiality information provision. The item, "To what extent do you think Robert is aware of the limits of confidentiality in therapy?" (Appendix B, item 15), was used as a manipulation check to ascertain whether respondents perceived differences on confidentiality information provision in conditions one and three (inform) vs. conditions two and four (no inform.) A 2 x 2 Anova (severity x information provision) performed on this variable yielded a significant main effect for information provision, $F(1, 243)=94.56$, $p<.0001$, $d=1.25$. No main effect for severity, $F(1, 243)=.87$, $p>.10$, $d=.12$, and no severity x information provision interaction were found, $F(1, 243)=.18$, $p>.10$, $d=.05$.

The mean response on the "client awareness" item was 3.22 for the inform conditions and 1.92 for the no inform conditions. These means correspond to a scale value between "Somewhat aware" and "Quite aware" for the inform conditions, and between "Not at all aware" and "Slightly aware" for the no inform conditions. It is important to note that this item provides only an approximate check on the quality of this particular manipulation, because it is possible that responses

to previous items on the survey influenced responses to the "client awareness" item. For example, respondents' reporting decisions could have influenced responses to a subsequent item related to client awareness of confidentiality information.

Reliabilities of Multi-item Dependent Variables

Dissonance. The six items designed to measure dissonance (Appendix B, items 1-6) were submitted to a reliability analysis, yielding Cronbach's alpha coefficient (see Table 3). One item ("I would feel uncomfortable or uneasy at this point in the session") had an item-total correlation of less than .40, and therefore was eliminated. The remaining five items yielded a scale with a standardized alpha coefficient of .87. The mean scale score was then standardized, and comprised the "dissonance" variable in regression analyses reported later.

Certainty of abuse. Reliability analyses on the three items designed to measure certainty of abuse (Appendix B, items 9-11) yielded item-total correlations above .60 (see Table 4). The alpha coefficient for the resulting "certainty of abuse" scale was .81.

Justifications for failure to inform. Three items were designed to assess different ways that respondents could justify their failure to inform clients of confidentiality limits. It was hypothesized that respondents could justify this behavior by citing one or all of the reasons for the necessity or risk of involving Child Protective Services (CPS)

Table 3

Means and item-total correlations of dissonance scale items

<u>Item</u>	<u>M</u>	<u>SD</u>	<u>Item-total correlation</u>
Deceive ^a	4.17	1.62	.70
Unethical ^b	2.90	1.80	.78
Adverse ^c	4.17	1.62	.50
Critic ^d	2.47	1.58	.76
Guilt ^e	2.79	1.66	.78
Total	15.71	6.81	

Note: Item alpha for Dissonance scale = .873

^a "I would be concerned that Robert would feel that I had deceived him about my ethical and legal obligations as a therapist" (Appendix B, item 2.)

^b "I would be concerned that I had not acted responsibly or ethically toward my client" (Appendix B, item 3.)

^c "I would be concerned that my behavior regarding informing Robert of confidentiality limits could adversely affect the therapeutic relationship" (Appendix B, item 4.)

^d "I believe that my professional colleagues would question or criticize my behavior regarding informing Robert of confidentiality limits" (Appendix B, item 5.)

^e "In retrospect, I would feel regretful or guilty regarding my behavior toward my client" (Appendix B, item 6.)

Table 4

Means and item-total correlations of certainty scale items

<u>Item</u>	<u>M</u>	<u>SD</u>	<u>Item-total correlation</u>
Certain ^a	4.69	1.29	.69
Describe ^b	3.64	0.93	.62
Risk ^c	4.58	1.31	.70
Total	12.91	3.03	

Note: Item alpha for Certainty scale = .814

^a "How certain are you that Robert is mistreating/abusing his child?" (Appendix B, item 9)

^b "How would you describe Robert's behavior toward his son?" (Appendix B, item 10)

^c "How certain are you that Robert's child is at risk for physical harm?" (Appendix B, item 11)

Table 5

Means and item-total correlations of CPS-related justification items*

<u>Item</u>	<u>M</u>	<u>SD</u>	<u>Item-total correlation</u>
CPS-Robert ^a	4.57	1.32	.32
CPS-Steven ^b	2.82	1.33	.24
CPS-Unnecessary ^c	3.17	1.55	.31
Total	10.55	2.93	

Note: Item alpha for Justification scale = .465.

* Because of insufficient internal consistency of proposed scale, the three CPS items were retained as individual criterion variables.

^a "I believe that reporting this case to Child Protective Services could adversely affect my client Robert's treatment" (Appendix B, item 12)

^b "I believe that reporting this case to Child Protective Services could jeopardize the safety of Robert's child, Steven" (Appendix B, item 13)

^c "I believe that I could handle this case most effectively without the intervention of Child Protective Services" (Appendix B, item 14)

in the case presented. These "justifications" included perceived risk to Robert's treatment (Appendix B, item 12), perceived risk to the child (item 13), and the belief that the case could best be handled without CPS intervention (item 14).

The three justification items did not have high inter-item correlations (see Table 5); consequently, the three-item scale yielded an alpha coefficient of .470. Therefore, the three justification items related to CPS intervention were not combined and were used as individual dependent variables in subsequent analyses.

Tests for Differences on Dependent Variables Across Conditions

Each of the seven dependent variables in the model were submitted to separate 2 x 2 (severity x information provision) analyses of variance in order to determine whether there were differences on these variables across the four conditions. These analyses revealed that five of the seven dependent variables of interest varied significantly by condition. See Table 6 for mean scores on the dependent variables across the four conditions. Because there were no statistically significant interaction effects in these analyses, mean scores across manipulations (severity and information provision) that correspond to main effects are provided in the text below.

Dissonance by condition. In this analysis, main effects were found for both information provision, $F(1,243)=139.60$, $p>.0001$, $d=1.52$, as well as severity, $F(1,243)=5.35$, $p<.05$,

Table 6

Mean scores and standard deviations of variables by condition

<u>Variable</u>	<u>Condition</u>			
	Low severity/ Inform	Low severity/ No inform	High severity/ Inform	High severity/ No inform
	<u>n=64</u>	<u>n=52</u>	<u>n=58</u>	<u>n=74</u>
	<u>M</u> <u>(SD)</u>	<u>M</u> <u>(SD)</u>	<u>M</u> <u>(SD)</u>	<u>M</u> <u>(SD)</u>
Dissonance ^a	11.17 (3.91)	18.30 (6.38)	11.87 (4.63)	20.78 (6.09)
Certainty ^b	11.70 (2.92)	10.98 (3.22)	14.10 (2.25)	14.15 (2.64)
Reporting ^c	3.95 (1.77)	3.94 (1.88)	5.07 (1.40)	4.61 (1.68)
CPS-Robert	4.69 (1.22)	4.52 (1.28)	4.36 (1.36)	4.64 (1.40)
CPS-Sтивен	2.78 (1.37)	2.72 (1.29)	2.88 (1.39)	2.88 (1.27)
CPS- Unnecessary ^d	3.05 (1.51)	3.50 (1.53)	2.86 (1.61)	3.32 (1.54)
Client Awareness ^e	3.14 (1.52)	1.86 (.90)	3.33 (1.28)	1.93 (.94)

^a Main effects for information provision, $F(1,243)=139.60$, $p<.0001$, and for abuse severity, $F(1,243)=5.35$, $p<.05$

^b Main effect for abuse severity, $F(1,243)=61.62$, $p<.0001$

^c Main effect for abuse severity, $F(1,242)=16.97$, $p<.0001$

^d Main effect for information provision, $F(1,241)=5.20$, $p<.05$

^e Main effect for information provision, $F(1,243)=94.56$, $p<.0001$

$d=.30$. The severity x information provision interaction was not significant, $F(1,243)=1.67$, $p>.10$, $d=.17$. Looking first at the main effect for information provision, the mean dissonance score in the "inform" conditions was 11.50, compared to a mean score of 19.77 in the "no inform" conditions. Clearly, respondents in the latter conditions reported that they would feel much more discomfort subsequent to the client's disclosure of abuse. This finding is important because it was a central, and necessary, piece of the hypothesized model.

The main effect of abuse severity on dissonance was an unexpected finding, considering that an information provision x severity interaction (which could have been explained adequately by the hypothesized model) was not found. Respondents in the low severity conditions reported less dissonance ($M = 14.33$) than those in the high severity conditions ($M = 16.87$).

Certainty of abuse by condition. As expected, respondents in the high severity conditions indicated significantly greater certainty that abuse was occurring ($M=14.13$) compared to respondents in the low severity conditions ($M=11.38$), $F(1,243)=61.62$, $p<.0001$, $d=1.0$. Certainty of abuse did not vary significantly between the information provision conditions, $F(1,243)=.782$, $p>.10$, $d=.11$. Again, the severity x information provision interaction did

not reach significance in this analysis, $F(1, 243)=1.17$, $p>.10$, $d=.14$.

Reporting tendency by condition. Both severity of abuse and confidentiality information provision were predicted to influence reporting behavior. However, this analysis revealed a main effect for severity only, $F(1,242)=16.97$, $p<.0001$, $d=.53$. As expected, respondents in the high severity conditions were more likely to report ($M=4.81$) than were respondents in the low severity conditions ($M=3.95$).

Contrary to predictions, no main effect for information provision emerged, $F(1,242)=1.37$, $p>.10$, $d=.15$. The mean reporting responses between the information provision conditions were extremely close: 4.48 in the "inform" groups and 4.34 in the "no inform" groups. Neither was the interaction significant, $F(1,242)=1.06$, $p>.10$, $d=.13$.

CPS intervention variables by condition. 2 x 2 (severity x information provision) ANOVAs on the justification variables related to the impact of CPS intervention on Robert's treatment (Appendix B, item 12) and on the safety of Robert's child Steven (Appendix B, item 13) yielded no main effects or interactions.

However, information provision was related to the perception that the case described could best be handled without CPS intervention (Appendix B, item 14), $F(1, 241)=5.20$, $p<.05$, $d=.29$. Respondents in the "no inform"

conditions were significantly more likely to agree that CPS intervention was unnecessary ($M=3.39$) compared to those in the "inform" conditions ($M=2.96$). Severity of abuse was not related to this CPS variable, $F(1,241)=.862$, $p>.10$, $d=.12$, and no interaction was found, $F(1,241)=.000$, $p>.10$.

Client awareness by condition. On the client awareness item (Appendix B, item 15), a main effect was found for information provision, $F(1,243)=94.56$, $p<.0001$, $d=1.25$. No main effect for abuse severity, $F(1,243)=.87$, $p>.10$, $d=.12$, nor an information provision x severity interaction, $F(1,243)=.180$, $p>.10$, $d=.05$ were found. The main effect of information provision on the client awareness item was not surprising given that this item was also used as a manipulation check for information provision.

Relation of Demographic Characteristics to Dependent Variables

Reported previously were findings by Nicolai and Scott (1994) that certain characteristics of psychologists such as theoretical orientation, years of experience, past reporting behavior, and typical practices in informing clients of confidentiality limits are related to abuse reporting behavior. The impact of these variables, as well as respondents' sex, state, and work setting, on the constructs of interest in this study were evaluated via multiple regression analyses.

In order to ensure adequate cell sizes for two of the

demographic categories -- theoretical orientation and work setting -- several response categories were collapsed. On the theoretical orientation variable, cognitive and behavioral categories were combined, and humanistic, family systems, and other categories were combined into one "other" category. This procedure yielded four theoretical orientation groups: cognitive and behavioral (71, 28.9%), eclectic (72, 29.0%), psychodynamic (58, 23.6%), and other (45, 18.3%). On the work setting variable, respondents were divided into those who worked in private practice settings (151, 61.4%) and those who worked in other, non-private practice settings (95, 38.6%).

Past reporting behavior was measured by determining whether respondents suspected more incidents of child abuse in the last three years (Appendix B, item 26a) than they reported (item 26b). Thus, respondents were divided into "nonsuspectors" (97, 39.1%), "consistent reporters" (88, 35.5%) and "inconsistent reporters" (63, 25.4%).

Because the model under investigation had two distinct components, or "submodels" -- one for low severity abuse (conditions one and two) and one for high severity abuse (conditions three and four) -- it was necessary to examine whether the relation of respondents' demographic/practice characteristics to the dependent variables in the model was affected by abuse severity.

Therefore, utilizing the entire data set, each of the

seven dependent variables in the model was regressed on the set of demographic/practice characteristics. Abuse severity level was included in this first set of regressions. If the severity x demographic/practice characteristic interactions were collectively significant for any one dependent variable, the data were split into low and high abuse severity conditions and a second set of regressions (one for low severity and one for high severity) were performed on that particular dependent variable.

Results of the multiple regression analyses involving the constructs of interest on the demographic and practice variables are presented in Appendix C in Tables C1 through C10. Additionally, each table delineates results of the initial regression that included the severity x demographic/practice characteristic interactions.

Relation of demographic/practice characteristics to dissonance. First, utilizing the entire data set (i.e., both low and high severity data) the measure of dissonance was regressed on the set of demographic and practice characteristics. The severity interactions were not significant, $F(22,208) = .99$, $p > .10$, indicating that the relation of these characteristics to dissonance did not differ by severity condition. Therefore, results of the regression of dissonance on the demographic/practice characteristics for the entire sample are presented in Appendix C, Table C1. The

effect of demographic/practice characteristics was not significant, $F(11,219)=1.10$, $p>.10$, and accounted for only 5% of the variance in dissonance scores.

Relation of demographic/practice characteristics to abuse certainty. Second, the measure of certainty of abuse was regressed on the set of demographic and practice characteristics, again utilizing the entire data set. This time the severity interactions were significant, $F(22,208)=3.73$, $p<.0001$, suggesting that the relation of demographic/practice characteristics to abuse certainty varied by severity condition. Therefore, the data were divided into low and high severity conditions, and separate regressions were performed on the certainty of abuse variable. In the low severity analysis (Table C2), the contribution of the demographic/practice variables accounted for a nonsignificant 9% of the variance in abuse certainty, $F(11,96)=.82$, $p>.10$.

However, in the high severity submodel, demographic/practice characteristics accounted for 18% of the variance in abuse certainty, $F(11,111) = 2.15$, $p<.05$. Examination of Table C3 reveals that respondents' years of experience was a significant predictor of abuse certainty in the high severity conditions. Specifically, more experienced respondents were less convinced that abuse had occurred in these conditions.

Additionally, there was some evidence that respondents'

state of practice was related to abuse certainty, with Connecticut respondents tending to be less certain that Robert had abused his child. This finding must be interpreted with caution, however, as a one-way ANOVA yielded no significant differences among states on certainty of abuse, $F(2,236)=2.22$, $p>.10$.

Relation of demographic/practice characteristics to reporting. The regression of reporting on the demographic/practice variables for the total sample also yielded significant severity interactions, $F(22,207)=3.20$, $p<.0001$. Regressions performed on reporting in both the low and the high submodel are presented in Tables C4 and C5, respectively, of Appendix C.

Demographic/practice characteristics were strongly predictive of reporting behavior in both submodels, accounting for 20% of the variance in the low severity submodel, $F(11,95)=2.17$, $p<.05$, and 22% of the variance in the high severity submodel, $F(11,111)=2.89$, $p<.01$. In both submodels, respondents' years of experience was significantly related to reporting behavior. Corresponding to this variables' relation to abuse certainty, more experienced respondents were less likely to say they would report the abuse depicted in the clinical vignettes.

Additionally, respondents' reporting histories were predictive of reporting behavior in both the low and the high

severity submodels. Not surprisingly, consistent reporters were more likely to say they would report the incident, and inconsistent reporters were less likely to say they would report.

No other demographic variables were predictive of reporting behavior in the low severity submodel, but respondents' state was related to reporting behavior in the high severity submodel. Similar to findings on the abuse certainty variable, Connecticut practitioners were less likely to indicate that they would report the incident if they were Dr. H. Because a one-way ANOVA found no differences in reporting scores among the states, $F(2,235)=1.40$, $p>.10$, the same caution regarding interpreting state differences on this variable is warranted.

Relation of demographic/practice characteristics to CPS-related "justification" variables. Each of the three CPS variables was regressed on the set of demographic and practice characteristics; analyses on each variable are reported separately. The severity x demographic/practice characteristic interactions in the regression of CPS-Unnecessary (Appendix B, item 14) were not significant, $F(22,206)=1.02$, $p>.10$. Furthermore, the set of demographic characteristics explained a nonsignificant 6% of the variance on this item, $F(11,217)=1.26$, $p>.10$ (see Table C6).

On the item pertaining to the perceived effect of CPS

intervention on the client Robert's treatment (Appendix B, item 12), Table 7 shows that abuse severity did not influence the relation of demographic/practice characteristics to this variable, $F(22,207)=1.04$, $p>.10$. The set of demographic/practice variables were not significantly related to CPS-Robert scores, $F(11,218)=1.45$, $p>.10$, and explained only 7% of the variance on this item.

Finally, abuse severity did influence the relation of the justification variable assessing respondents' belief that CPS intervention could jeopardize the safety of Robert's child Steven (Appendix B, item 13) to demographic and practice characteristics, $F(22,207)=2.03$, $p<.01$.

Demographic/practice characteristics explained a nonsignificant 12% of the variance in CPS-Steven scores in the high severity submodel, $F(11,111)=1.37$, $p>.10$ (see Table C8). In the low severity submodel (Table C9), demographic/practice variables accounted for 26% of the variance in CPS-Steven scores, $F(11,95)=3.00$, $p<.01$. Theoretical orientation was the only individual variable significantly related to scores on this item, with cognitive/behavioral and psychodynamic clinicians tending to disagree that CPS intervention could jeopardize Steven.

Relation of demographic/practice characteristics to client awareness of confidentiality limits. The item pertaining to client awareness of the limits of confidentiality was regressed on the set of demographic/practice variables, again including severity x demographic/practice interaction terms. A nonsignificant effect was observed for severity, $F(22,208)=1.06$, $p>.10$, indicating that the relation of these variables did not differ by the level of abuse severity. Additionally, the set of demographic/practice characteristics accounted for only 5% of the variance in awareness scores, $F(11,219)=1.13$, $p>.10$.

Summary of relation of demographic/practice characteristics to dependent variables. Among the constructs of interest in the proposed model, certainty of abuse and reporting tendency were significantly influenced by individual demographic/practice characteristics (explaining from 9% to 20% of the variance on these two variables). First, more experienced practitioners were less certain that the vignette depicted an abusive event in the high severity conditions, and were less likely to say they would report in both the low and high severity conditions. Additionally, respondents' reporting history was consistent with their tendency to report in this study. Finally, respondents' state of practice appeared to predict abuse certainty as well as reporting tendency to some degree, with Connecticut practitioners

apparently being less certain and less likely to report.

Path Analyses and Model Testing

This section is divided into three parts. The first, "Path Analyses of Submodels," explains the first steps of path analysis which involve calculating beta weights and R^2 values for each predicted path, or relationship, between constructs in the model. Taking the most conservative approach to analyzing these data, all demographic and practice variables were entered first into each regression equation (for each hypothesized relationship) in order to control for possible effects of respondent characteristics. Thus, beta weights and R^2 values represent the unique effects of the predictors on the criterion variables. Findings for both the low severity submodel and the high severity submodel are presented.

The second part of this section, "Testing the Models," describes the final steps of the path analyses in which the predicted models are tested for their "goodness of fit" to the data. Again, findings regarding the "fit" of both the low severity and the high severity submodels to the data are presented.

The third part of this section covers additional analyses based on the model. These analyses examined the relation of dissonance to comfort in reporting decision, and the use of client awareness of confidentiality information as a dissonance reduction strategy. Finally, a revised model based

on the findings is suggested for further investigation.

Path Analyses of Submodels

In order to guide readers through the figures presenting the models (Figures 3, 4, 5, and 6), a brief explanation of how the figures can be read follows. First, Figures 3 and 5 correspond to the low severity submodel, and Figures 4 and 6 correspond to the high severity submodel. The first figure in each set represents the predicted model, called the "reduced model" in path analytic terms. The second figure in each set is the "fully recursive model," representing a model in which all possible paths, or relationships, among the constructs of interest are examined. The relation of the reduced model to the fully recursive model will be examined in the second section, "Testing the Models."

At the far left of each figure is a symbol labeled "Confidentiality Information Provision." This symbol represents the manipulated exogenous variable pertaining to whether the clinician depicted in the vignette provided information about confidentiality limits to the client. Confidentiality Information Provision (inform/no inform) was treated as the sole exogenous variable in each of the two submodels. (Note: Although abuse severity could also be considered an exogenous variable, the severity manipulation was addressed by proposing distinct high and low severity submodels).

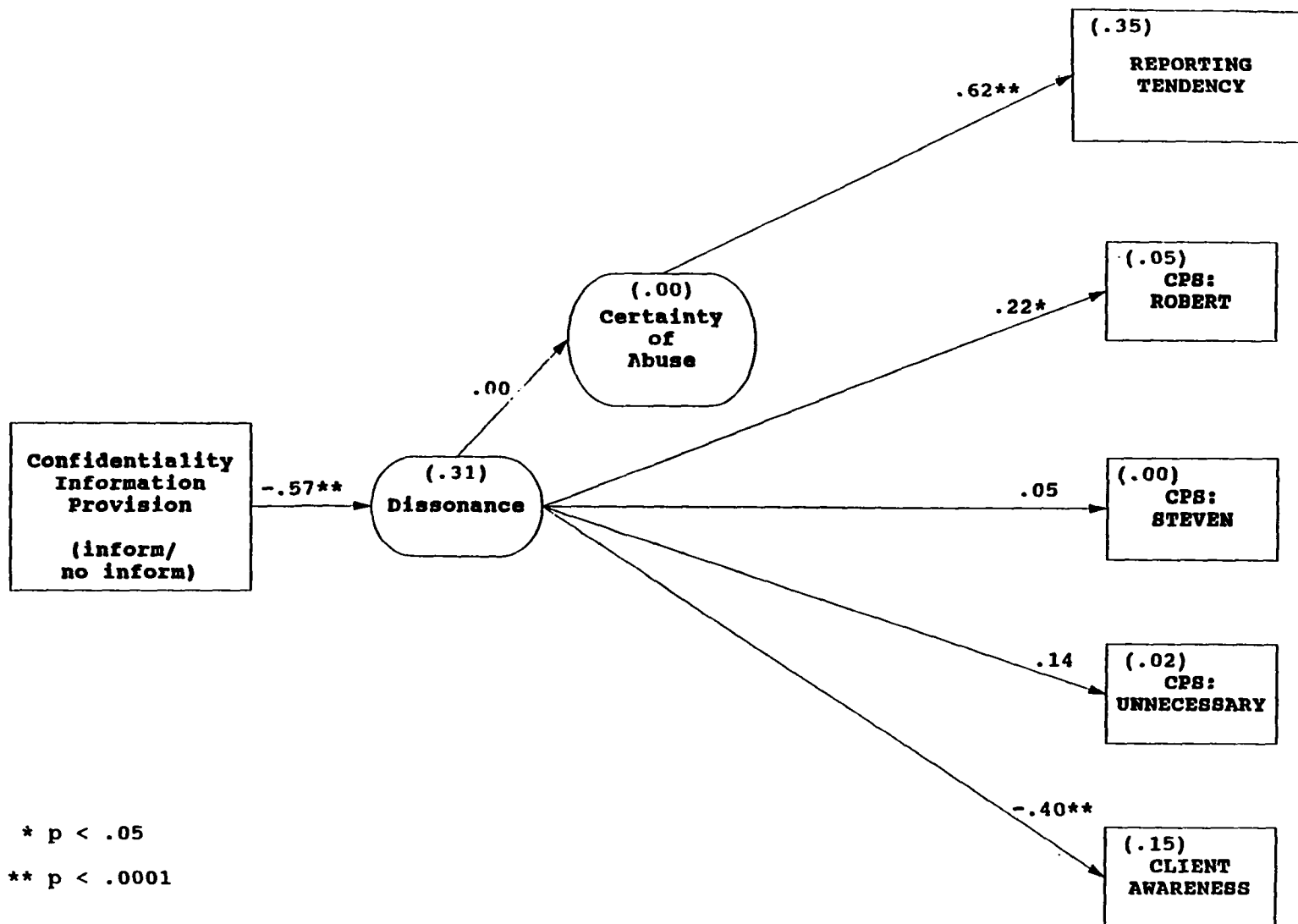
To the right of "Confidentiality Information Provision" are two other construct symbols, labeled "Dissonance" and "Certainty of Abuse." These symbols represent the endogenous predictor variables in the model. Finally, at the far right of each figure are symbols that represent the four endogenous criterion variables in the predicted (reduced) model: Reporting Behavior, three justification variables labeled CPS-Robert, CPS-Steven, and CPS-Unnecessary, and Client Awareness.

Each pathway in the model figures is described in two ways. The coefficient shown on each pathway is the standardized beta weight resulting from the regression of construct "x" on at least one other construct assumed to predict construct "x." The number in parentheses contained within each symbol in the figures represents R^2 , the variation in each endogenous variable that is explained by the predictor variable(s) after controlling for demographic and practice characteristics.

Low severity submodel: Reduced. Figure 3 depicts the reduced, or hypothesized, model of the relationships among the constructs of interest when clinicians are faced with a reporting decision involving low severity abuse. Separate regressions were performed for each endogenous variable in the model.

Several significant pathways were predicted in the Low Severity submodel. First, Confidentiality Information

Figure 3: Reduced low severity submodel



Provision was employed as the sole predictor of Dissonance. It was expected that compared to informing clients of confidentiality limits, not informing clients of limits would result in more dissonance. Figure 3 shows that this relationship was significant and in the expected direction ($B = -.57$, $p < .0001$), with Confidentiality Information Provision accounting for 31% of the variance in Dissonance scores.

Second, Dissonance was the sole predictor of Certainty of Abuse in the submodel. It was expected that this would be an inverse relationship, with low dissonance predicting high abuse certainty and vice-versa. Figure 3 clearly shows that Dissonance was not related to Certainty of Abuse, accounting for virtually none of the variance in certainty scores.

However, the relation of Certainty of Abuse to Reporting Behavior was significant and in the expected direction ($B = .62$, $p < .0001$), explaining 35% of the variance in reporting scores. Respondents who were more certain that abuse had occurred were more likely to report.

The reduced model also hypothesized that dissonance would be the sole predictor of the three CPS variables designed to capture respondents' attempts to justify their failure to provide confidentiality information. Figure 3 indicates that Dissonance was a significant predictor in the expected direction of the CPS-Robert variable ($B = .22$, $p < .05$), explaining 5% of the variance in scores. Respondents who

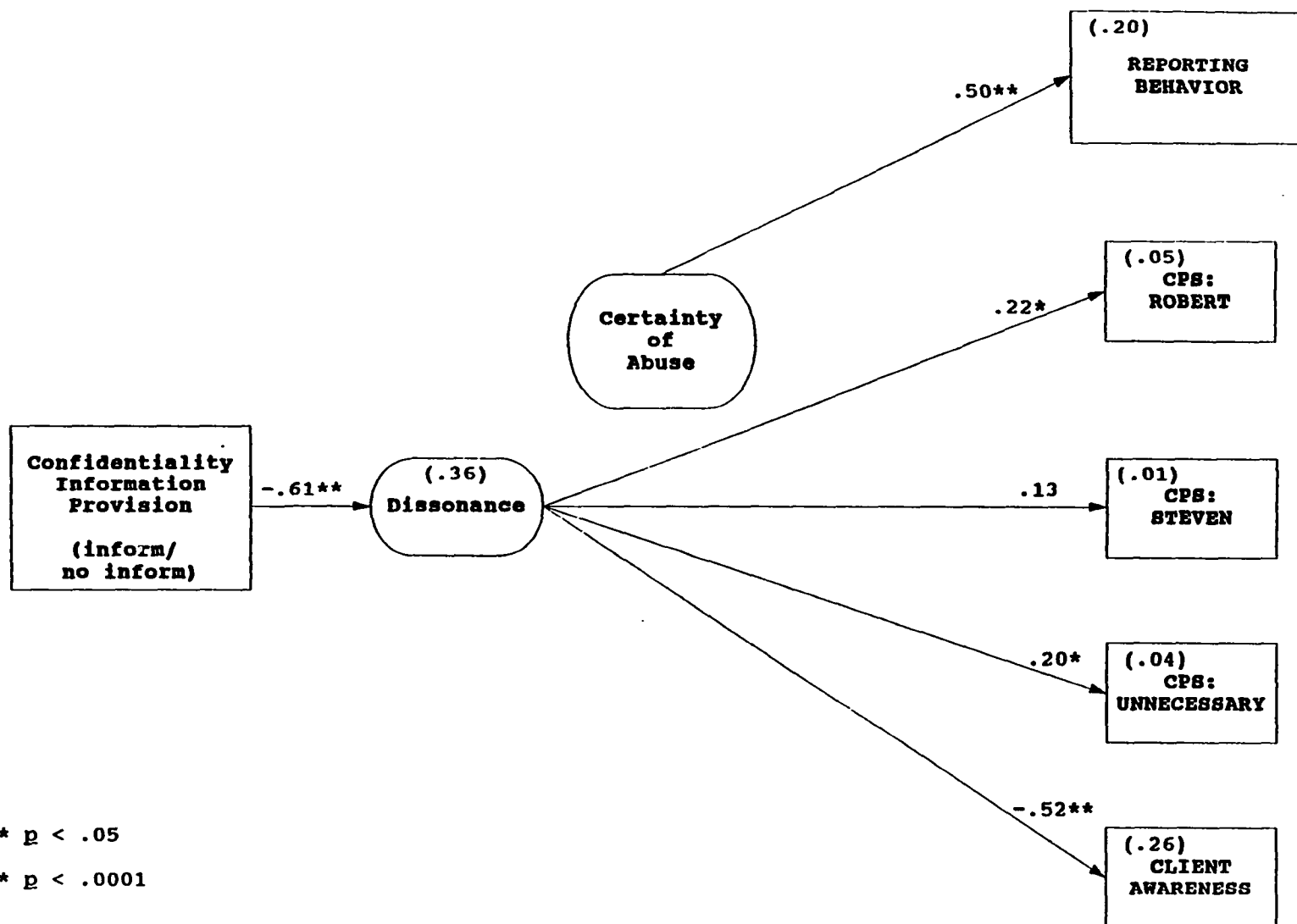
indicated feeling more discomfort were also more likely to believe that CPS intervention would adversely affect Robert's treatment. Dissonance was not significantly related to either CPS-Steven or CPS-Unnecessary.

Dissonance also predicted client awareness of confidentiality limits ($B = -.40$, $p < .0001$), explaining 15% of the variance in scores on this item. Not surprisingly, respondents who reported more discomfort around "their" provision of confidentiality information were less likely to perceive that the client was in fact aware of the limits of confidentiality in therapy.

High severity submodel: Reduced. Path coefficients and R^2 values for the predicted paths in the high severity (reduced) submodel are depicted in Figure 4. Provision of Confidentiality Information was again used as the sole predictor of Dissonance scores. This relationship was significant and in the expected direction ($B = -.61$, $p < .0001$), with information provision accounting for 36% of the variance in dissonance scores.

The primary difference between the low severity submodel and the high severity submodel was related to predictions regarding the effect of dissonance on certainty of abuse and subsequent reporting behavior. Unlike the expected relationship among these variables in the low severity submodel, it was predicted that dissonance would not affect

Figure 4: Reduced high severity submodel



certainty of abuse or reporting behavior in the high severity submodel. Thus, Figure 4 shows no path between Dissonance and Certainty of Abuse.

As expected, Certainty of Abuse was a significant predictor of Reporting Behavior ($B=.50$, $p<.0001$) in the high severity submodel, accounting for 20% of the variance in reporting scores.

Dissonance was employed as the sole predictor of the three CPS-related justification variables in the high severity submodel. These analyses yielded two significant relationships in the expected direction. Dissonance scores were predictive of respondents' belief that CPS intervention would adversely affect Robert's treatment ($B=.22$, $p<.05$), and of respondent's opinion that they could handle the case most effectively without CPS intervention ($B=.20$, $p<.05$). Dissonance scores did not predict respondent's belief that CPS intervention could jeopardize the safety of Robert's child, Steven; Dissonance explained only 1% of the variance in CPS-Steven scores.

Finally, Dissonance explained 26% of the variance in scores on the Client Awareness item ($B=-.52$, $p<.0001$). As predicted, respondents who indicated more dissonance regarding the provision of confidentiality information were less likely to perceive that the Robert was aware of confidentiality limits in the vignette.

Testing the Models

The path analytic strategy compares the reduced model to the fully recursive model via a "goodness of fit" calculation resulting in a statistic known as "Q." Q describes the proportion of variance explained by the reduced model relative to the variance explained by the fully recursive model (see Pedhazur, 1982, for a detailed explanation of this statistic and its calculation).

Q is then tested for statistical significance using a chi-square test. If this test is nonsignificant, the investigator can conclude that the hypothesized model fits the data as well as the fully recursive model; therefore, he or she will not reject the hypothesized model. A significant chi-square test indicates that the fully recursive model was able to explain significantly more variation in the endogenous variables than the reduced hypothesized model. In other words, a significant chi-square test suggests that the investigator has failed to include pathways in his or her model that explained significant variance in the data. In this case, the investigator is forced to conclude that his or her model did not fit the data, and a revised (post-hoc) model may be constructed.

Low severity submodel: Reduced vs. fully recursive.

Comparisons of the beta weights of paths between the low severity reduced submodel and the fully recursive submodel can

be made by examining Figure 3 and Figure 5, respectively. The low severity submodel yielded a "goodness of fit" index, or Q, of .715, suggesting only a modest fit of the model to the data. As a consequence, the chi-square test of the low severity model was significant, $X^2(n=116, 11)=35.30, p<.01$. Therefore, it was concluded that the fully recursive model contained paths that accounted for a significant proportion of variance over the reduced model.

Figure 5 shows three paths missing from the reduced model that were significant in the fully recursive model. Confidentiality Information Provision was predictive of the CPS-Robert criterion ($B=.25, p<.05$), and Certainty of Abuse was significantly related to a belief that CPS intervention was unnecessary ($B= -.30, p<.01$).

Furthermore, Confidentiality Information Provision was a significant predictor of Client Awareness ($B=.36, p<.001$). This finding is not surprising, as the client awareness item was used as a manipulation check for perceived differences in confidentiality information provision.

High severity submodel: Reduced vs. fully recursive.

Calculation of Q in the high severity submodel yielded a goodness-of-fit index of .731, and a chi-square test performed on the submodel was again significant, $X^2(n=132, 12)=37.68, p<.01$. Comparison of the reduced submodel (Figure 4) to the fully recursive submodel (Figure 6) indicates that a

Figure 5: Fully recursive low severity submodel

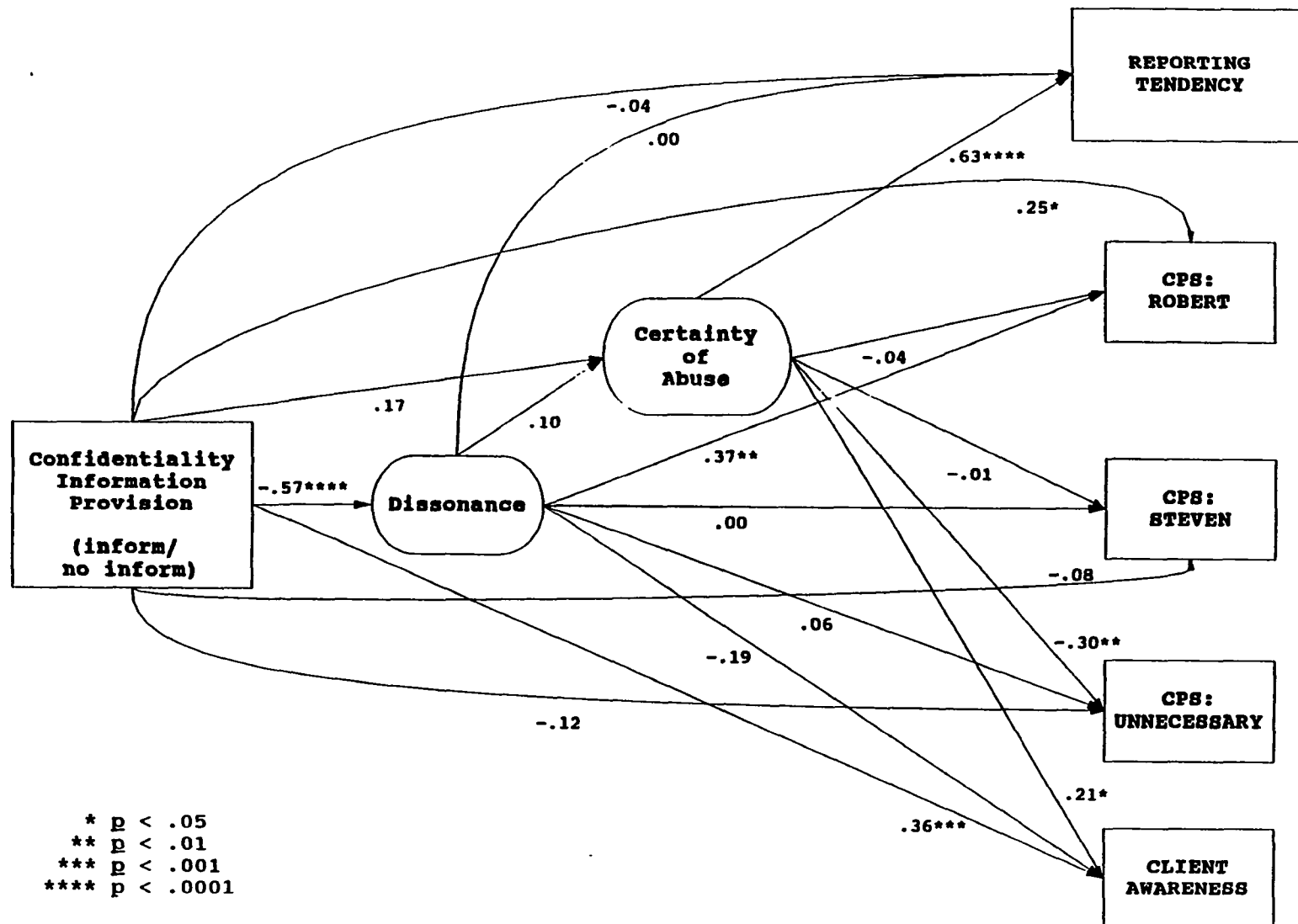
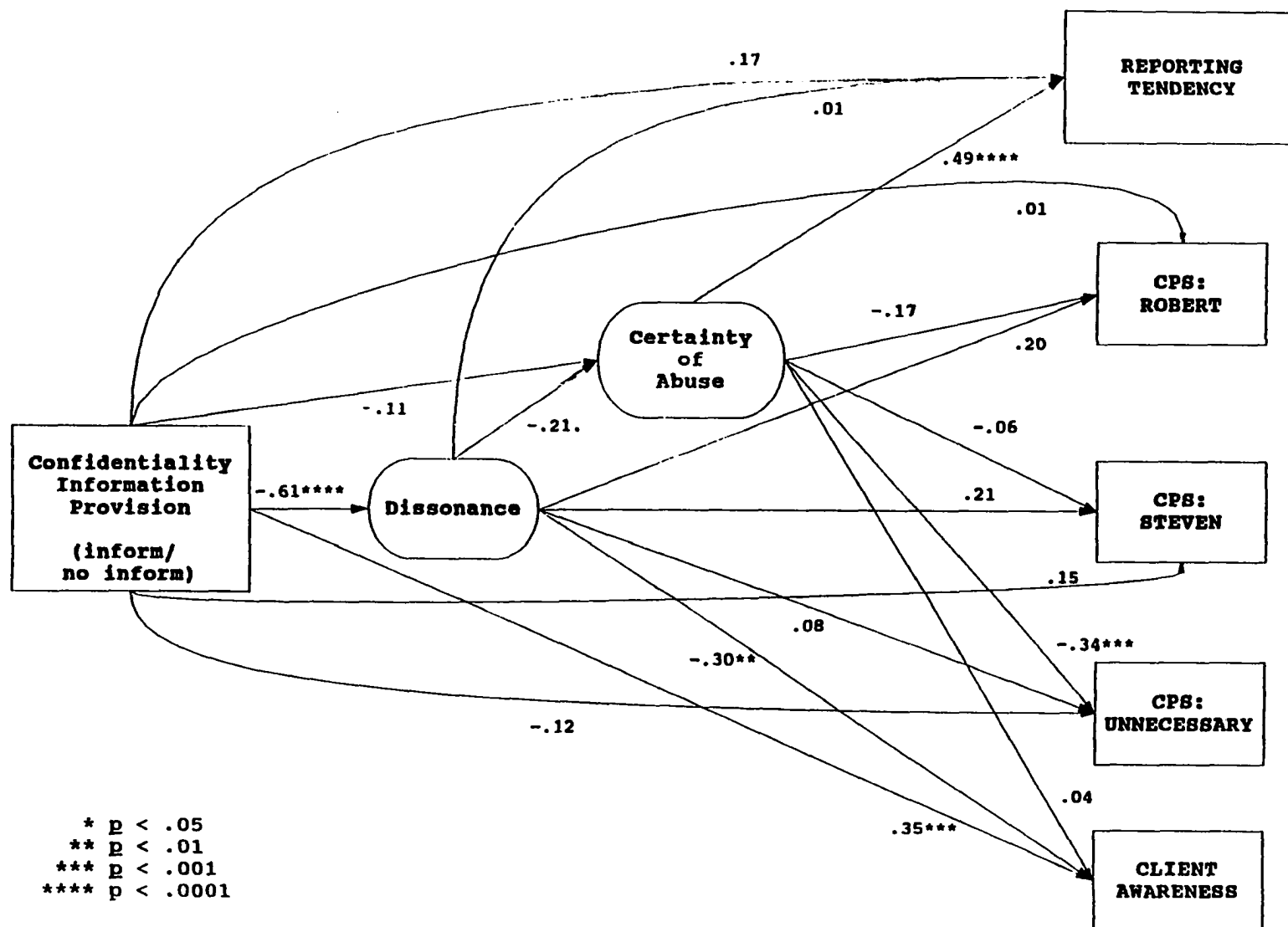


Figure 6: Fully recursive high severity submodel



significant path between Certainty of Abuse and belief that CPS intervention is unnecessary ($B = -.34$, $p < .001$) was missing from the predicted model.

Similar to the finding in the comparison of the low severity submodels, a second significant path missing from the reduced model was between Confidentiality Information Provision and Client Awareness ($B = .35$, $p < .001$). The fact that Dissonance remained a unique predictor of Client Awareness ($B = -.30$, $p < .01$) even after the Confidentiality Information Provision-Client Awareness path was included in the model provides support for the hypothesized model, and will be discussed later in the next chapter. No other paths were significant in the fully recursive model that were not included in the reduced model.

However, another finding that was quite interesting and unexpected involved the marginally significant relation between Dissonance and Certainty of Abuse in the high severity recursive submodel ($B = -.21$, $p = .06$). An unpredicted relation such as this must be interpreted with much caution, but will be discussed briefly in the next chapter.

Additional Analyses Related to the Model

Use of Client Awareness as a dissonance reduction strategy. In order to determine whether respondents used the perception that the client was not aware of confidentiality limits as a dissonance reduction strategy, respondents were

divided into "Reporter" (i.e., those who said they would be slightly, somewhat, or very likely to report; $n=177$) and "Nonreporter" (i.e., those who said they would be slightly, somewhat, or very unlikely to report; $n=69$) groups.

It was expected that nonreporters' greater reliance on this strategy would be reflected in a more significant (negative) relationship between Dissonance and the Client Awareness variable as compared to the relationship between these variables in the reporter group.

However, correlations performed on these two variables indicated that the (negative) relation of Dissonance and Client Awareness was even stronger in the reporter group ($r=-.52$, $p<.001$) than the nonreporter group ($r=-.30$, $p<.05$). Thus, it appears that the prediction that changes in perceptions about the client's awareness of limits was not used as a dissonance reduction strategy as anticipated.

Relation of Dissonance to comfort in reporting decision.

The comfort in reporting decision item (Appendix B, item 8) was included in the survey instrument because it is possible that respondents' comfort in regard to reporting suspected abuse could be very indicative of how they might respond in actual practice. In order to test the general hypothesis that dissonance influences how comfortable clinicians feel in reporting suspected abuse, several correlations were performed.

First, the correlation of reporting tendency and comfort in reporting decision resulted in a Pearson's r coefficient of .22 ($p < .001$), suggesting that respondents who would report the abuse presented in the vignette were also more comfortable with their decision than those who would not report. Second, although dissonance was not related to reporting ($r = -.01$, $p > .10$), it was significantly related to comfort in reporting decision ($r = -.18$, $p < .01$). Specifically, respondents who indicated feeling more discomfort about "their" provision of confidentiality information were also less comfortable with their reporting decision.

Therefore, because reporting was positively related to decision comfort, and dissonance appeared to inhibit this comfort, it might be that in clinicians' actual practices, dissonance could result in greater hesitancy to report suspected abuse.

Summary of Findings Related to Submodels

Neither of the hypothesized models efficiently explained the data compared to the fully recursive models. First, it appears that the relation of dissonance to abuse certainty and subsequent reporting did not vary by severity of abuse as expected. In fact, a marginally significant relation between dissonance and abuse certainty in the high severity recursive submodel emerged.

Only one of the hypothesized relations between dissonance

and the CPS-related justification variables was supported. Dissonance was predictive of the opinion that reporting the case to CPS could adversely affect the client Robert's treatment. The predicted significant relations of dissonance to the belief that CPS intervention was unnecessary, and to the belief that reporting the case to CPS could jeopardize Steven, were not supported.

Furthermore, although dissonance was significantly related to the perception that the client was less aware of confidentiality limits, the hypothesis that this perception would reflect an attempt to reduce dissonance was not supported.

Finally, dissonance appeared to be related to how comfortable respondents were about their reporting decisions. Higher dissonance was associated with lower decisional comfort.

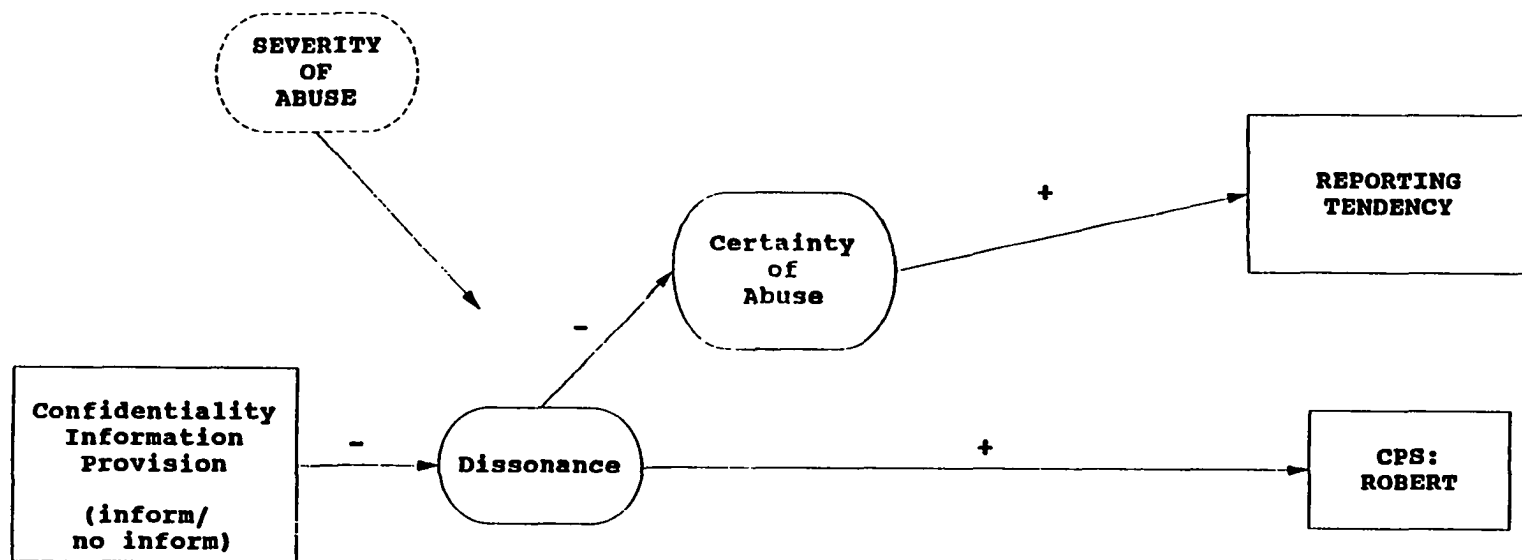
Revised Model of Reporting Behavior

Based on an examination of findings from the path analyses, a revised model of reporting behavior within the conceptual framework of dissonance theory is suggested (see Figure 7) for future study. Variables that appeared to be unrelated to confidentiality information provision and dissonance were eliminated from the model. Specifically, CPS-Steven and CPS-Unnecessary were eliminated on these grounds. Additionally, because Client Awareness was not used as a

dissonance reduction strategy as expected, this construct was also dropped from the proposed model. Finally, in order to test the hypothesis that severity moderates the relation of Dissonance to Certainty of Abuse, this construct is included in the proposed model. It is suggested, however, that the abuse severity be manipulated more clearly, with moderate abuse (e.g., a black eye) and severe abuse (e.g., sexual abuse) presented in the vignettes.

What remains is a proposed model to test and replicate the findings of this investigation. This utility of this model can be determined only through a replication of this study; therefore, no analyses to test the "fit" of the revised model were performed.

Figure 7: Revised model of reporting behavior



DISCUSSION

The primary aim of this study was to examine whether the failure to inform clients of confidentiality limits influences subsequent behavior in regard to child abuse reporting decisions. A causal model of reporting behavior was constructed that attempted to explain the relation of (a) the provision of confidentiality information to clients who disclose either high or low severity abuse to (b) decisions and perception relating to reporting suspected child abuse. It was posited that dissonance mediates the relation of confidentiality information provision to reporting behavior.

The following chapter is presented in several parts. First, the discussion begins with a brief description of the characteristics of respondents in the sample. Particular attention is paid to respondents' typical practices in regard to the provision of confidentiality information to clients, as well as to their child abuse reporting histories.

The central thrust of this study was the development and examination of a model of reporting behavior that was based on both theoretical and empirical foundations. Therefore, the bulk of the discussion focuses on various aspects of this model, beginning with a brief review of constructs in the model within the framework of cognitive dissonance theory.

Findings related to the seven endogenous variables in the model are presented, including (1) the effect of the

manipulated conditions on the endogenous variables, and (2) the influence of demographic and practice characteristics on the endogenous variables.

Next, the efficiency of the hypothesized model of reporting behavior is examined by exploring its "fit" to the data. A revised model of reporting behavior is suggested, as well as a discussion of implications for practicing psychologists.

Finally, strengths and limitations of this study are discussed. Issues related to the internal and external validity of the study are particularly relevant and are emphasized in this section. Additionally, implications for further research are explored.

Characteristics of Respondents and Their Practices Respondent Characteristics

Two hundred forty-eight psychologists licensed in Arkansas, Connecticut and New Mexico comprised the sample in this study. Most respondents held a Ph.D. and averaged over 16 years of clinical experience. The fact that respondents were seasoned professionals is important to the external validity of this investigation, as participants likely had experienced ethical dilemmas similar to the one explored in this study and could appreciate the challenges inherent in abuse reporting decisions.

Participants also subscribed to a range of theoretical

orientations. Eclectic, psychodynamic, and cognitive psychologists made up nearly two-thirds of the entire sample, and over 60% of the respondents worked in private or group practice settings.

Provision of Confidentiality Information to Clients

Although American Psychological Association (APA) ethical guidelines direct psychologists to inform their clients of the limits of confidentiality, studies of clinicians clearly indicate that many do not provide their clients with this information (Nicolai & Scott, 1994; Baird & Rupert, 1987; Handelsman et al, 1986). Over a third of the practitioners in this study indicated that, consistent with APA guidelines, they always provided this information. However, more than 60% of respondents were less consistent in their provision of confidentiality information to clients. Generally speaking, it appears that both practitioners and their agencies "sometimes" to "usually" provide information about confidentiality to clients.

This less-than-diligent provision of information about confidentiality limits to clients, by both individual practitioners and their agencies, is troubling. Without explicit presentation of information regarding confidentiality limits, the novice client may well assume that all disclosures, regardless of content, will be held in confidence. Because legal and ethical guidelines for mental

health professionals clearly state that clinicians must breach confidentiality under certain circumstances, the provision of a Miranda-type warning (e.g., "certain things you tell me can and probably will be held against you") to clients in therapy is advisable in order to protect both the interests of clients as well as their therapists.

Regarding the type of confidentiality information that is provided to clients, the vast majority of respondents (91.5%) indicated that specific information about confidentiality limits, including limits related to disclosures of threatened harm to self, threatened harm to others, and suspected child abuse was given to clients. This finding is encouraging because it suggests that when clinicians do provide information related to confidentiality limits to their clients, they are clearly delineating specific circumstances under which confidentiality might be breached. However, this finding must be tempered with practitioners' apparent inconsistency in the delivery of this information to their clients.

Approximately three-fifths of the practitioners in this study indicated that they had suspected at least one incident of child abuse in the prior three years. Among this group of respondents, approximately 58% indicated that they had consistently reported all suspected incidents of abuse, whereas about 42% had suspected more incidents than they

reported. The finding that over one-quarter of all the clinicians in this sample had not reported a suspected incident of child abuse is consistent with previous research on the reporting histories of clinicians (Kalichman & Craig, 1991; Nicolai & Scott, 1994). Further, that a substantial minority of respondents in this study have chosen not to report suspected abuse exemplifies the fact that many clinicians question the therapeutic wisdom of strict adherence to legal and ethical mandates to report abuse.

Dissonance Theory and the Hypothesized Model of Reporting Overview of Predictions Based on Dissonance Theory

This investigation examined the effects of clinicians' discomfort related to their failure to inform clients of confidentiality limits on subsequent child abuse reporting decisions. Predictions about the relation of respondents' subjective discomfort to reporting behavior were made within the framework of cognitive dissonance theory (Festinger, 1957), which is briefly reviewed.

Cognitive dissonance, a state of psychological discomfort, leads to attitude and/or behavior change when people (1) expect that their behavior is, was, or will be associated with an aversive or unpleasant consequence, (2) perceive that their behavior is irrevocable, and (3) perceive that they have the freedom of choice and are responsible for engaging in a behavior (Worchel, Cooper, & Goethals, 1988).

Festinger (1957) asserted that the mechanism or process underlying dissonance-produced attitude change involves people's attempts to engage in strategies that will allow them to regain a sense of psychological consistency or comfort.

In this study, respondents were presented with a clinical vignette that depicted a client disclosing information indicative of either low severity (a whipping) or high severity (a whipping and a black eye) child abuse. In the vignette, the clinician either had or had not provided the client with information regarding the limits of confidentiality. The situation in which a clinician has not informed his/her client of confidentiality limits -- and the client subsequently discloses potentially reportable information regarding child abuse -- was conceptualized as the dissonance-arousing event.

Further, it was argued that the conditions necessary for dissonance arousal and attitude/behavior change articulated by Worchel, Cooper, and Goethels, (1988), were met when clinicians' reporting decisions were considered in the context of whether they had (or had not) informed clients of confidentiality limits regarding suspected child abuse. Specifically, clinicians who fail to inform their clients of confidentiality limits (a freely chosen, irrevocable behavior), and whose client subsequently discloses reportable information will anticipate the potential adverse effects of

their behavior on a "betrayed" client, harm to the therapeutic relationship, and damaged identities as ethical professionals (unpleasant consequences).

In the present study, dissonance was manipulated by asking respondents to take the place of the clinician in the vignette after he/she had or had not provided information related to confidentiality. This study attempted to measure the cognitive components of dissonance directly by assessing the extent to which respondents would feel concerned or guilty about "their" behavior regarding the provision of confidentiality information to the client, Robert.

Because slightly different sets of relations were posited depending on whether the abuse depicted was of low or high severity, two submodels (low and high severity) were constructed. The predicted relations among constructs in the model are summarized next.

Dissonance, a central component of the model, was expected to be high in participants who were asked to respond to the "no inform" conditions. It was predicted that, in the low severity conditions only, respondents would attempt to reduce "their" dissonance by distorting (i.e., minimizing) the severity of the abuse depicted, and consequently being less likely to say they would report the case to CPS. Therefore, Certainty of Abuse and Reporting Tendency were constructs included in the model.

Further, it was predicted that respondents would use additional strategies to reduce dissonance in both the low and the high severity conditions. These strategies included asserting that the case could best be handled without CPS intervention (CPS-Unnecessary), or by indicating that CPS intervention would have adverse effects on Robert's treatment (CPS-Robert) or jeopardize the safety of the child (CPS-Steven). As compared to the more direct measure of reporting tendency, the CPS variables were used as indirect measures of reporting behavior. For example, a clinician's belief that he/she could handle the case most effectively without CPS intervention is clearly related to whether that clinician would breach confidentiality and report the case to CPS.

Additionally, respondents could decide that the client was more or less aware of confidentiality limits (Client Awareness) in order to justify a reporting decision. Evidence of the use of this dissonance reduction strategy would come from comparatively lower Client Awareness scores in those who said they would report the abuse presented in the vignette.

Effect of Conditions on Model Constructs

An important step in the analyses of these data was the determination of whether the endogenous variables in the model differed across the four manipulated conditions. These analyses attempted to answer the question, "Did the manipulations affect the constructs in the model consistent

with predictions?"

The influence of the conditions on dissonance was of particular importance. After respondents were asked to put themselves in the place of Dr. H., a clinician who either did or did not inform the client of confidentiality limits, respondents reported how concerned, responsible, guilty, etc. they would feel regarding "their" behavior toward the client. In other words, respondents were asked to take the place of Dr. H. and rate the degree of discomfort or dissonance they imagined they might have experienced in the situation described.

The finding that compared to the "inform" conditions, the "no inform" conditions generated significantly higher ratings of dissonance supplied the necessary foundation for the remaining pieces of the model. Unexpectedly, the severity manipulation also resulted in higher dissonance scores. Because the items designed to capture dissonance were specifically related to confidentiality information provision, it was surprising that a main effect for abuse severity was found. It may be that the dissonance scale tapped into a more general state of discomfort than was anticipated; if this was the case, higher dissonance scores generated by conditions depicting a more serious and challenging ethical dilemma would not be surprising.

Respondents' certainty of abuse and reporting tendency

were both influenced by the severity conditions. Not surprisingly, clinicians who responded to the vignettes depicting more severe abuse (a whipping and a black eye) were more certain that abuse had occurred and were more likely to say that they would report the case to CPS. In the abuse reporting literature, perceived severity of abuse is a consistent predictor of reporting behavior (e.g., Kalichman et al, 1988; Finlayson & Koocher, 1991; Beck & Ogloff, 1995).

On the other hand, the provision of confidentiality information affected neither abuse certainty nor reporting tendency. The latter finding was not consistent with the prediction that clinicians who failed to inform their clients of confidentiality limits would be more hesitant to report.

However, the provision of confidentiality information manipulation did influence the perception that the case described could best be handled without CPS intervention. Specifically, respondents in the "no inform" conditions were significantly more likely to agree that CPS intervention was unnecessary compared to those in the "inform" conditions. This finding is important because the perceived necessity of involving CPS in a case is obviously related to whether a clinician might breach confidentiality in order to report that case to CPS.

It may be that clinicians who fail to provide confidentiality information believe they could handle the case

most effectively without CPS intervention because of perceived negative effects that breaching confidentiality and reporting this situation might have on the client, or on the client's child. However, the manipulated conditions did not affect responses to the item pertaining to adverse effects of CPS intervention on the client's treatment, nor to the item assessing the potential for harm to his child as a result of reporting to CPS. Together, these findings suggest the possibility that a clinician's failure to provide confidentiality information could result in hesitancy to report suspected abuse to CPS, irrespective of any perceived impact CPS involvement might have on the client or his/her child.

Finally, respondents' perceptions that the client was aware of confidentiality limits varied significantly by condition. Specifically, respondents in the "inform" conditions were more likely to indicate that the client was aware of limits, compared to those in the "no inform" conditions. This finding provided evidence that the manipulation involving confidentiality information provision had the desired effect.

Relation of Demographic and Practice Characteristics to Dependent Variables

Previous research has indicated that demographic and practice characteristics of psychologists sometimes influence

their reporting decisions. In this study, multiple regression analyses were conducted in order to examine the potential effects of selected demographic and practice characteristics on the endogenous and dependent variables in the hypothesized model of reporting behavior.

Respondents' sex, state of practice, years of experience, theoretical orientation, practice setting, frequency of the provision of confidentiality information to clients in their own practices, and child abuse reporting history comprised the set of demographic/practice characteristics examined. Each of the endogenous variables in the hypothesized model -- dissonance, abuse certainty, reporting tendency, the three justification variables related to CPS intervention, and perceptions of the client's awareness of confidentiality information -- were regressed on the set of demographic/practice characteristics.

The set of demographic/practice characteristics was not significantly related to dissonance, to the belief that CPS intervention would have an adverse effect on the client Robert's treatment, to the opinion that the case could be handled most effectively without CPS intervention, or to the perception that Robert was aware of confidentiality limits.

However, demographic and practice characteristics were significantly related to (a) respondents' certainty that the case vignette depicted an instance of child abuse (explaining

9% and 18% of the variance in the low and high severity submodels, respectively), (b) reporting tendency (accounting for 20% and 22% of the variance in the low and high severity submodels, respectively), and (c) the perception that reporting could jeopardize the safety of Robert's child, Steven (explaining 26% and 12% of the variance in the low and high severity submodels, respectively).

Specifically, respondents' years of experience was a significant predictor of abuse certainty, but only in the high abuse severity condition. Furthermore, years of experience predicted reporting tendency in both the high and the low severity conditions. Compared to respondents with fewer years of experience, more experienced practitioners were less convinced that abuse had occurred (when the abuse depicted was less severe), and were less likely to say that they would report the incident to Child Protective Services.

The finding that more experienced clinicians were less certain that abuse had occurred, and were less likely to report, could be interpreted in several ways. For example, it may be that through experience, clinicians become more cautious in terms of inferring abuse based on limited information, leading to decreased reporting. Or, it is possible that as clinicians gain more experience working with a range of clients and their families, they become less convinced that reporting abuse to child protective services

facilitates treatment. Alternatively, clinicians who have practiced for many years might hold a qualitatively different set of assumptions about what constitutes abusive behavior compared to their younger counterparts.

Unfortunately, the cross-sectional design of this study does not permit a clear interpretation of the finding that years of experience seems to be related to decreased abuse certainty and reporting. Longitudinal investigations are virtually nonexistent in the child abuse reporting literature, and could generate interesting information regarding the influence of experience on reporting decisions.

Second, respondents' reporting history was predictive of reporting behavior. Not surprisingly, compared to practitioners who were "consistent reporters" of suspected child abuse, those who had not reported incidents of suspected abuse in the previous three years were less likely to say that they would report the incident depicted in the vignette. This finding is consistent with previous research in this area (Nicolai & Scott, 1994; Kalichman & Craig, 1991).

There was some mixed evidence that respondents' state of practice was related to certainty of abuse and to reporting behavior in the high, but not the low, severity conditions. Respondents practicing in the state of Connecticut were less convinced that abuse was depicted in the vignette, and were less likely to indicate that they would report the incident.

Finally, the only justification variable that was related to the set of demographic and practice variables was the belief that CPS intervention could jeopardize the safety of Robert's child, Steven. In the high severity conditions only, respondents' theoretical orientation explained significant variance in scores on this variable. Specifically, cognitive and behavioral clinicians, as well as psychodynamic clinicians, were less likely to believe that CPS intervention would jeopardize Steven's safety.

Tests of the Proposed Model

The primary aim of this study was to test a theory-driven causal model that focused on dissonance arousal and reduction processes as the mechanism underlying the predicted relation of confidentiality information provision to reporting decisions and justifications. Hypothesized significant relations among endogenous variables for the low abuse severity and high abuse severity conditions were identical with the exception of one predicted pathway. Specifically, dissonance was expected to predict abuse certainty (and subsequent reporting tendency) when the suspected abuse was less severe; alternatively, no relationship between dissonance and abuse certainty was predicted in cases of high abuse severity. Therefore, two distinct submodels -- corresponding to low severity and high severity abuse -- were posited.

The hypothesized submodels were tested against the fully

recursive submodels in order to determine whether they provided a good "fit" to the data. Results of the chi-square tests to determine the efficiency of both predicted submodels revealed that neither model adequately explained variance in the data. The reasons for the poor fit of the hypothesized model to the data appeared to be twofold. First, the prediction that dissonance would influence abuse certainty in conditions depicting low severity abuse, but would not influence abuse certainty in high severity conditions, was not supported. In fact, comparison of the beta weights of the predicted paths in the low and high severity submodels suggests very similar relations among variables; therefore, it appears that the creation of distinct low and high severity submodels was not entirely supported.

The second explanation for the poor fit of the model is that several pathways not included in the hypothesized submodels were significant in both the low and high severity recursive submodels. These findings are included in the discussion below, which begins by examining the relations among endogenous variables in the model as depicted in the figures from left (Confidentiality Information Provision) to right (Reporting Tendency, the CPS variables, and Client Awareness). First, Confidentiality Information Provision was employed as the sole predictor of Dissonance in both the low and the high severity submodels. As hypothesized, compared to

informing clients of confidentiality limits, not informing clients of limits resulted in more dissonance. Corroborating the qualitative information reported by Levine et al. (1992), this finding provided the first piece of empirical evidence supporting the causal connection between the provision of confidentiality information and subsequent discomfort or dissonance associated with the failure to inform clients of limits.

The primary difference between the low severity and the high severity submodels was related to predictions regarding the effect of Dissonance on Certainty of Abuse (and subsequent reporting tendency). Specifically, Dissonance was the sole predictor of Certainty of Abuse in the low abuse severity submodel only. It was expected that this would be an inverse relationship, with low dissonance predicting high abuse certainty and vice-versa. However, these analyses clearly showed that Dissonance was not related to Certainty of Abuse.

Alternatively, it was predicted that when abuse severity was high, whatever discomfort clinicians might experience as a result of failing to provide information about confidentiality limits would be overshadowed by the perceived necessity to report (as a function of their certainty that abuse had occurred). Thus, no relationship between Dissonance and Certainty of Abuse was predicted in the high severity submodel. However, an unexpected, marginally significant

relation between these two variables emerged in the high severity recursive submodel. Examination of this submodel shows that the relationship between Dissonance and Certainty is negative. The conclusion that discomfort might reduce clinicians' estimates of abuse severity is a very tentative one, and could be drawn only through a more convincing replication of the finding.

That the relation of dissonance to abuse certainty was contrary to hypotheses could be explained in two ways. First, it may simply be that discomfort related to the failure to provide confidentiality information is not reduced by distorting abuse-related information. Perhaps because evidence of abuse is relatively concrete (e.g., a verbal statement made by a client, cuts and bruises, etc.) this information is not very susceptible to distortion.

The second explanation is slightly more complicated. It was expected that changing one's certainty of abuse would be perhaps the most "drastic" dissonance-reduction strategy that respondents could use, because it would require a shift in the perception of concrete information rather than opinions or attitudes (e.g., opinions related to CPS intervention). Further, it is likely that in order for clinicians to be motivated to use this dissonance reduction strategy, a certain level of discomfort would have to be experienced. Too little discomfort would not motivate the clinician to use this more

drastic strategy. On the other hand, it was also expected that regardless of the level of dissonance experienced by respondents, the recognition of very severe abuse would inhibit the use of this particular dissonance-reduction strategy.

It might be that a nonsignificant relation between Dissonance and Certainty of Abuse was found in the low severity conditions because the lower dissonance "threshold" that would motivate the information-distortion strategy was not reached. Alternatively, the marginally significant relation between Dissonance and Certainty of Abuse in the high severity conditions could be interpreted as supportive of the general hypothesis if an assumption is made that (1) the dissonance "threshold" was reached and (2) the abuse depicted was not severe enough to inhibit the use of the information-distortion dissonance reduction strategy. Again, these explanations are speculative and could only be supported through further study and replication of findings.

Next, the relation of Certainty of Abuse to Reporting Behavior was significant and in the expected direction for both the high and low severity submodels. As reported earlier in this chapter, previous research in this area has found abuse certainty to be a consistent predictor of reporting tendency.

Both the low and the high severity submodels hypothesized

that Dissonance would be the sole predictor of the three CPS variables, which were designed to capture respondents attempts to justify their failure to provide confidentiality information. These variables were also utilized as indirect measures of reporting tendency.

First, Dissonance was a significant predictor in the expected direction of the CPS-Robert criterion in both the low and the high severity submodels. Respondents who indicated feeling more discomfort were also more likely to believe that CPS intervention would adversely affect Robert's treatment.

Additionally, an unpredicted significant relation was found between Confidentiality Information Provision and the CPS-Robert criterion in the low severity recursive submodel only; it appears that in the "no inform" conditions, respondents were more likely to say that reporting the case to CPS would have an adverse effect on Robert's treatment. However, Dissonance remained a unique predictor of CPS-Robert even after the Confidentiality Information Provision to CPS-Robert pathway was added to the recursive model.

Together, findings on the significant predictors of CPS-Robert were very supportive of the hypothesis that the failure to provide confidentiality information results in magnified concerns about the negative impact that reporting suspected abuse might have on clients. Because previous research has linked these concerns to lower reporting rates (Kalichman,

1989), it seems reasonable to expect that the failure to provide confidentiality information to clients, and subsequent dissonance, might also be associated with decreased reporting.

Second, higher Dissonance scores were predictive of respondents' opinion that they could handle the case most effectively without CPS intervention in the high severity conditions. However, not included in either of the hypothesized submodels was the significant pathway between Certainty of Abuse and CPS-Unnecessary found in both the low and high severity recursive submodels. When this pathway was included in the fully recursive models, the relation between Dissonance and CPS-Unnecessary became nonsignificant. In other words, it appears that while these results provided some weak evidence for the relation of dissonance to the perception that CPS intervention is unnecessary, certainty of abuse was a much stronger predictor of this criterion.

Third, Dissonance scores did not predict respondent's belief that CPS intervention could jeopardize the safety of Robert's child, Steven, in either the high or the low severity submodels. It is possible that dissonance "experienced" by respondents motivated those strategies exclusively related to Robert's treatment (i.e., CPS-Robert, CPS-Unnecessary, and Client Awareness). If this is the case, respondents' beliefs about whether reporting the case to CPS would jeopardize Steven would be entirely distinct from their discomfort around

"betraying" their client, Robert.

Finally, the prediction that Dissonance scores would predict Client awareness of confidentiality information in both the high and the low severity submodels was supported. Respondents who indicated feeling more discomfort regarding "their" failure to provide confidentiality information were also more likely to say that the client was not aware of those limits.

Additionally, comparison of the reduced to the fully recursive models indicated that a significant path between Confidentiality Information Provision and Client Awareness was missing from the hypothesized model. Given the fact that the client awareness item was utilized as a manipulation check for the confidentiality information provision manipulation, the absence of this path from the hypothesized model was a clear oversight in its development.

More interesting is the fact that Dissonance remained a unique predictor of Client Awareness even after the Confidentiality Information Provision-Client Awareness path was included in the recursive model. Thus, it appears that the variance of scores on Client Awareness was attributable to more than simply the manipulation; respondents' subjective discomfort in regard to "their" behavior also predicted their evaluation of client awareness of confidentiality information.

Further analyses revealed, however, that perceiving that

the client was unaware of confidentiality limits was not utilized as a dissonance-reduction strategy as anticipated. The expectation that compared to reporters, nonreporters would use this strategy in order to justify their (non)reporting decision was not supported. Specifically, the relation between Dissonance and Client awareness was actually stronger for reporters.

Summary and Integration of Findings

Overall, the hypothesized model of the relation of dissonance to reporting behaviors received minimal support, and did not appear to "fit" the data very well. The hypothesis that the failure to provide information regarding confidentiality limits to clients results in dissonance, which in turn is related to reporting behavior, was only partially supported.

First, the information provision manipulation did result in the desired effect of heightened discomfort in the "no inform" conditions. Further, Dissonance was significantly related to the perception that reporting the case to CPS would have adverse effects on the client's treatment. Because previous research has found a link between such perceptions and nonreporting, the relation found in this study was probably the most convincing piece of evidence that the failure to provide confidentiality limits to clients can result in magnified concerns about the effect of reporting on

treatment, and possibly in lower reporting rates.

Second, the prediction that Dissonance would influence Certainty of Abuse in the low, but not the high, severity conditions was also not supported. Interestingly, a marginally significant relation between these two variables emerged in the high severity conditions. Further investigation could determine whether, and under what circumstances, dissonance reduces clinicians' certainty that abuse has occurred and inhibit reporting.

However, the fact that respondents' reporting tendencies were positively related to being comfortable with this decision, and that higher dissonance was associated with lower comfort scores, provided some additional evidence that the provision of confidentiality information might be related to how comfortable (and therefore how likely) clinicians might be to report abuse in actual practice.

Third, the hypothesized relation between Dissonance and the perception that the case could be handled most effectively without CPS intervention (CPS-Unnecessary) received only minimal support; after the contribution of Certainty of Abuse to CPS-Unnecessary was accounted for, the hypothesized relation became nonsignificant. Interestingly, one set of analyses indicated that compared to respondents in the "inform" conditions, those in the "no inform" conditions were more likely to believe that the case could be handled most

effectively without CPS intervention. Thus, the relationships between the provision of confidentiality information, dissonance, and CPS-Unnecessary were somewhat unclear.

Finally, although Dissonance was related to the perception that the client was less aware of confidentiality limits (Client Awareness), this perception did not appear to reflect an attempt to reduce dissonance as anticipated.

In sum, it appears that the findings minimally supported the utility of cognitive dissonance theory as an explanatory framework for the predicted relations of confidentiality information provision to reporting behaviors. The finding that discomfort related to the failure to provide clients with confidentiality information was related to magnified concerns about reporting suspected abuse was consistent with the dissonance framework. Additionally, the possible link between dissonance and decreased certainty of abuse also holds promise for future researchers interested in this study's conceptualization of reporting decisions.

Implications of Findings for Practitioners

The clinical situation depicted in the vignette clearly resonated with respondents, many of whom commented (some at length) about their own thoughts and experiences in regard to the ethical dilemma(s) explored in this study. This section highlights implications of this study's findings for practitioners; written comments of the respondents are used to

illustrate that the dilemma examined in this investigation is one with which many clinicians are very familiar.

One clear implication of these findings for practitioners is that the provision of confidentiality information is a necessary, and often overlooked, part of the informed consent procedure that protects both client and clinician. As one respondent observed,

"Dr H. exposed himself/herself to clinical complications by not informing the client of the limits of confidentiality..."

Furthermore, it appears that the failure to provide this information to clients before the commencement of therapy can sometimes result in clinical dilemmas that are markedly uncomfortable for both parties. In fact, these findings provided some support for the hypothesis that the failure to provide confidentiality limits to a client who later discloses reportable information can result in magnified concerns about adverse effects of reporting on treatment. In this vein, a respondent wrote:

"One very often neglects to inform clients of the limits of confidentiality at the outset because we assume that child abuse is not an issue. When we find out that it is, we find ourselves in a very awkward dilemma indeed. 'Popping' [limits of confidentiality] on the client later in the process is probably more harmful to therapeutic rapport than having the issue discussed up front, in the beginning..."

Another respondent who was in the "no inform" condition wrote the following comment, which is interesting in that

although he/she states that the client would be provided with confidentiality information, no mention of reporting the incident is made...

"This is one of those 'oh, shit' scenarios -- I guess I would lay out the confidentiality issues to Robert and try to get him to agree that he will leave the scene if he feels like hitting the child, and that I will help him learn to calm himself and learn [a more effective method] of discipline..."

In fact, some respondents seemed to articulate very succinctly a corollary of this investigation's primary hypothesis -- that informing clients of confidentiality limits enhances clinicians' comfort in reporting suspected abuse. For example, one respondent wrote,

"Every new client receives and signs [a form delineating limits of confidentiality]...this allows me to feel very free to breach confidentiality in those rare cases of threatened harm to self or others."

Another made this brief, to-the-point observation...

"Frankly, I do not understand the controversy. tell the adult the limits of confidentiality, and then follow through with what you say and be consistent. This is easy!"

Previous research has identified a number of factors, such as the type and severity of abuse, that seem to influence reporting behaviors of clinicians. Virtually none of these previously identified factors are within the clinician's control. The findings of this study are encouraging because they represent evidence that the provision of confidentiality information, a behavior that is entirely under the control of the clinician, might enhance practitioners' adherence to

mandatory reporting laws.

It is important to note, however, that although the provision of confidentiality information might be one factor that influences reporting decisions for some clinicians, whether or not the client has been informed of limits might be irrelevant to the reporting decisions of others. For most clinicians, perhaps the primary motivation to report suspected abuse is the protection of the child. As one of the respondents in this study commented,

"...the child's welfare is the paramount consideration in determining whatever course of action I undertake, and not (I repeat not) any feelings of ambivalence I harbor about whether a client is or is not aware of the limits of confidentiality."

Finally, a significant proportion of respondents' comments related to Child Protective Services. While many respondents stated that involving CPS is probably necessary (and certainly required by law) in cases of suspected abuse, they also shared their concerns about the effectiveness of CPS intervention...

"Many times when suspected abuse is reported, there is no investigation. In these cases, the client may not return for treatment and no intervention takes place in the home."

"Any ambivalence I feel about reporting stems from the quality of intervention from CPS, which is grossly underfunded and understaffed..."

"In many cases [CPS] is slow and ineffectual in responding...[as a result] the child may be at increased risk."

Lastly, some comments reflected the sentiments of this respondent:

"Therapists can often, in a case like Robert's, do much more to prevent recurrent or ongoing abuse than Child Protective Services, which often interferes with the therapy..."

In response to clinicians' growing dissatisfaction with mandatory reporting legislation and the quality of state intervention in cases of suspected child abuse, Finkelhor and Zellman (1991) proposed a set of "flexible reporting options" that would allow trained and registered clinicians to defer mandated reports under certain circumstances. Unfortunately, it is not possible to discuss Finkelhor and Zellman's innovative ideas here; suffice it to say that their proposal addresses many of the concerns expressed by the respondents in this study, and its adoption would likely result in more positive relationships between clinicians and Child Protective Services.

Strengths and Limitations of the Study

This section addresses some of the more salient strengths and limitations of this investigation. A notable strength of this study -- a survey method that employed the random assignment of participants to conditions -- also presented its most significant problems related to both external and internal validity. Therefore, the focus of the following discussion is on the strengths and limitations associated with this investigation's design/method.

First, survey research tends to have inherent limitations. The possibility of response bias is a potential issue, particularly when controversial and sensitive information is requested from participants (e.g., whether respondents adhere to ethical and/or legal guidelines in their therapy practices). The threat of response bias was addressed in this study by ensuring the anonymity of respondents, but it is possible that a positive bias (e.g., inflated estimates of confidentiality information provision) was present in these data.

Additionally, the extent to which respondents in this study were representative of psychologists in general, or even of psychologists within the three states samples, is unknown. Unfortunately, demographic data on psychologists within the states surveyed were not secured; therefore, comparisons of this sample to the larger population were not made. However, respondents' demographic characteristics were very similar to those of participants in a recent study by Nicolai and Scott (1994), who surveyed psychologists in three different states (Kansas, Minnesota, and Missouri).

Second, the "once removed" nature of the survey method, in its attempt to examine how subjects might respond if they were involved in a particular situation, is a limitation that has plagued researchers who (oftentimes for practical and/or ethical reasons) rely on this method of data collection.

Specifically, the extent to which a vignette presented in a survey can capture the complexities of any clinical situation, particularly one involving an ethical dilemma, is questionable.

Use of the survey method to examine the particular question in this study presented additional and somewhat unique problems. This investigation focused on an extremely complex series of events that can occur in the space of several minutes within a single therapy session. In other words, this study focused on a sequence of specific internal events (i.e., dissonance arousal and reduction processes) initiated by particular therapist and client behaviors (i.e., failure to provide confidentiality information and a disclosure of abuse). These events occur, for lack of a better term, in "real time."

In effect, this study attempted to create an analog of the "real-time" sequence of events described above. A vignette designed to manipulate dissonance arousal was presented to respondents, and was followed by a series of questions that attempted to measure cognitive processes that were assumed to occur subsequent to, or concurrent with, dissonance arousal. The sequence of dissonance arousal and reduction processes was assessed by presenting questions in a particular order that was consistent with this sequence of events as posited by dissonance theory.

Clearly, the use of a survey method to examine dissonance processes and their relation to reporting behavior presents several serious concerns in regard to internal validity. First, whether the items designed to measure dissonance actually were measuring this construct is debatable. Because participants were asked to respond to a hypothetical scenario as if they were the clinician in the scenario, it is unlikely that respondents themselves actually experienced significant arousal associated with "true" dissonance. Furthermore, the item that was eliminated from the Dissonance scale (Appendix B, item 1) due to a low item-total correlation was the item that probably tapped into the "feeling" dimension of dissonance the most. Second, the fact that dissonance did not seem to be tied to reporting behavior in this study but was related to the manipulation argues against the validity of the measure.

In addition, a legitimate argument could be made that despite its theoretical rationale, the presentation of items in a certain order is an overly simplistic procedure that cannot possibly capture the complex processes involving dissonance and subsequent reporting decisions adequately.

In actual practice, clinicians are free to choose whether they will or will not provide their clients with information about confidentiality limits. As discussed previously, one of the criteria necessary for the arousal of dissonance is the

perception of choice to engage in a behavior. The use of a vignette in which the clinician was portrayed as either informing or not informing clients of limits did not allow participants to make their own choices about whether this information would be provided. Thus, although it was unavoidable, the method used in this study violated one of the tenets of dissonance theory.

Another potential threat to internal validity relates to the possibility that the severity manipulation, rather than varying in abuse severity per se, actually varied in terms of the evidence of abuse presented in the vignette. Specifically, the "black eye" disclosed in the high severity conditions constitutes more concrete evidence of abuse compared to the "whipping" that may or may not have left marks described in the low severity conditions. In other words, it is possible that abuse severity and certainty of abuse were confounded in this study. Consequently, conclusions drawn in relation to the severity manipulations and respondents' certainty of abuse must be considered with caution.

On the other hand, the quasi-experimental survey method employed also lent several strengths to the study. First, along with the causal modeling/path analytic strategy, the random assignment of participants to conditions yielded a relatively powerful design that allowed for the establishment of directional relationships among variables.

Second, despite the potential problems regarding the measurement of dissonance cited earlier, the approach to examining dissonance arousal was somewhat unique and arguably a notable strength of this study.

Dissonance theory states that under certain circumstances, dissonance arousal mediates the relation between behavior/attitude A and (changed) behavior/attitude B. Rather than measuring dissonance directly, investigators usually examine the result of the manipulation on a target behavior that is assumed to reflect dissonance-produced attitude change.

In their review of the dissonance literature, Fazio and Cooper (1983) found very few studies that attempted to measure dissonance states directly. In fact, the only studies that appear to have examined dissonance per se (i.e., the actual state of psychological discomfort exclusive of subsequent attitude change) have focused on the physiological arousal that presumably accompanies the cognitive/affective aspects of dissonance. These investigators used induced compliance procedures in order to manipulate dissonance while monitoring subjects' electrodermal activity, a measure of physiological arousal (e.g., Croyle & Cooper, 1983). Although physiological arousal does seem to be a distinct component of dissonance, direct investigations of the cognitive aspects of dissonance per se are scarce (or nonexistent) in the literature.

Therefore, it is argued that one of the strengths of this study was the attempt to measure cognitive aspects, or specific upsetting thoughts, associated with dissonance arousal. Specifically, participants were asked to rate the extent to which they, "in the shoes of" the clinician depicted in the vignette, might experience concern or guilt in regard to their behavior. Although it could certainly be argued that self-report data are of questionable validity, and further that this study's "once-removed" survey design does not allow a true manipulation of dissonance processes, the fact remains that few, if any, studies have examined specific thoughts that are posited by theory to accompany dissonance arousal.

Finally, a large body of research pertaining to clinicians' reporting behavior exists; virtually all the studies comprising this literature examine factors influencing reporting decisions that have been identified on the basis of anecdotal, qualitative, and/or logical premises. In fact, a perusal of the reporting literature makes clear the conspicuous absence of theory-driven research in this area. Therefore, perhaps the most significant strength of this investigation was that hypotheses were formulated and conceptualized within a theoretical framework. In other words, a notable contribution of this study to its literature was an attempt to answer not only the "what?" questions regarding clinicians' reporting behavior, but also those

asking, "why?"

Directions for Future Research

First, the revised model of the relation of the provision of confidentiality information to reporting behavior needs to be supported or discarded. The effects of variations in the vignette could also be explored, such as varying the types of the abuse depicted (e.g., physical vs. sexual abuse), or the child (rather than the parent) being the client in the case. Additionally, future investigations could focus on the relation of the failure to inform clients of confidentiality limits to other breaches of confidentiality, such as those involving threatened harm to self or others.

Furthermore, the use of more ecologically valid designs to examine dilemmas involving the provision of confidentiality information is recommended. For example, rather than a survey method, videotaped scenarios could serve as stimuli in these investigations. In addition to potentially offering participants the opportunity to make their own choices regarding the provision of confidentiality information, this method might reflect the "real-time" sequence of events more accurately.

Concluding Comment

Findings from this investigation suggest that the provision of information regarding confidentiality limits to clients before the initiation of therapy could attenuate

clinicians' failure to report suspected child abuse to some degree. Additionally, it has been suggested that the provision of this so-called "Miranda warning" in therapy serves to protect the interests of both client and clinician. If, as a matter of agency policy and/or law, all therapy clients were informed of confidentiality limits, clinicians' vulnerability to legal and clinical problems associated with the failure to inform and to report suspected abuse might be ameliorated.

Discussed earlier was the finding that receiving information about confidentiality limits might inhibit some clients from disclosing that they have abused their children (Taube & Elwork, 1990) for fear of state intervention and/or legal repercussions. Many clinicians would balk at a more stringent ethical or legal requirement to inform clients of confidentiality limits prior to therapy for this very reason. In fact, the provision of confidentiality information to clients might very well result in increased numbers of unidentified victims of abuse.

It is important to point out that this study does not address the value or effectiveness of mandatory reporting laws, nor does it examine these statutes' success in achieving their intended goal of protecting children. Such a critique would be beyond the scope of this discussion. What is argued, however, is that as long as mandatory reporting statutes are

in place, clinicians must inform their clients that confidentiality is not absolute in therapy, and that certain disclosures are required by law to be reported to the state. Furthermore, it is the opinion of this author that doing otherwise constitutes a sort of "therapeutic entrapment" perpetrated by the clinician (intentionally or unintentionally) that does not do justice to the client's rights, and does not reflect well on the profession of psychotherapy.

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APPENDIX A

COVER LETTER AND SURVEY RESPONSE CARD

IOWA STATE UNIVER¹³⁶S
OF SCIENCE AND TECHNOLOGY

College of Liberal Arts and Science
Department of Psychology
W112 Lagomarcino Hall
Ames, Iowa 50011-3180
(515) 294-1742
FAX (515) 294-6424

February 20, 1995

Dear Colleague:

We are requesting your participation in a study of psychologists' practices in two areas: informing clients of confidentiality limits; and reporting child abuse. Studies have indicated that mandatory reporting of child abuse legislation has generated considerable controversy among psychologists who must balance their professional and ethical responsibilities of maintaining confidentiality with their legal obligations to report suspected cases of child abuse.

You have been selected to receive this survey because you are in a unique position to help provide a better understanding of current professional attitudes and practices in this area. It is precisely because of the controversial nature of issues surrounding informing clients of confidentiality limits and reporting child abuse that a accurate assessment of attitudes and practices is vital.

This research project has been reviewed and approved by the University Committee on Participants in Research and meets applicable ethical standards and guidelines. Your completion and return of the enclosed anonymous survey will constitute modified informed consent for participation in this project.

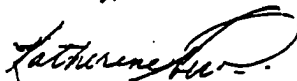
Completion of this anonymous survey will likely take about one half hour. Your response will be kept confidential and are anonymous; we ask that you do not put your name or any other identifying information anywhere on this survey.

The response card in this packet (to be returned separately) is coded with a number that does not appear anywhere on your survey or return envelope. The coded response cards will be used only so that we can send surveys to individuals who did not respond to the first mailing. At no time will completed surveys be associated with the code number or any other identifying information.

After completing the survey, please mail it in the postage-paid envelope provided. Also, please mail the enclosed response card separately so that your anonymity will be assured. We would appreciate a response by March 15.

We greatly appreciate your cooperation, and value your responses.

Sincerely,



Katherine Nicolai, M.S.
Principal Investigator



Norman Scott, Ph.D.
Associate Professor



Camilla Benbow, Ed.D.
Professor and Chair

SURVEY RESPONSE CARD

Please mark the appropriate statement below and return.

- ☒ I have completed and returned the Practitioner Survey separately to ensure my anonymity.
- ☐ I have decided not to complete and return the survey.

064

APPENDIX B
SURVEY INSTRUMENT

◆ PRACTITIONER SURVEY ◆

[When finished, please return the survey in the postage-paid envelope provided. Please do not write your name or any other identifying information on this survey. All responses are confidential.]

IMPORTANT! For the purposes of this study, please assume that your state's child abuse reporting law specifies that...

Any psychologist who has reasonable cause to know or suspect that any child has been subjected to abuse shall report.

Please carefully read the following scenario:

Dr. H. is a licensed psychologist working in a small group practice in a metropolitan area. He/she has received a referral from a colleague and today is meeting with the client for the first time. The client, Robert, is a 36-year-old man who presents with complaints of depression. Prior to this point, Robert has never received counseling or therapy. Robert and his wife have two children: Steven (age 10) and Michael (age 6). During the course of the interview, Robert states that over the past six months, Steven has become very defiant. He "talks back all the time" at home and has started several physical fights with his younger brother. At this point in the interview, Dr. H. begins to gather more information about Steven's behavior problems and how they are handled at home.

Dr. H.: What happens after Steven misbehaves or talks back at home?

Robert: Well, it drives me nuts. I have enough to worry about without him acting up all the time. The kid just doesn't seem to know when to quit. But I make sure he thinks twice about talking back to me again.

Dr. H.: How do you make sure of that?

Robert: I pull down his pants and give him a good whipping. After a few minutes of that, he doesn't talk back, believe me.

Dr. H.: After you whip him, do you notice marks or bruises on his behind?

Robert: I don't know...maybe, sometimes. But listen, doctor, it's the only way he learns anything! Believe me, a few marks on his behind is nothing compared to what I feel like doing sometimes.

Dr. H. must now decide whether to make a report of maltreatment/abuse to Child Protective Services. **Dr. H. HAS informed Robert of the limits of confidentiality**, including the fact that Dr. H. is legally obligated to report suspected child maltreatment/abuse.

Imagine that you are Dr. H. Consider how you might be feeling at this point in the session, prior to making a firm decision about whether to report. To what extent would you agree/disagree with the following statements:

1. I would feel uncomfortable or uneasy at this point in the session. (Circle only one number.)

1	2	3	4	5	6
Strongly disagree	Moderately disagree	Slightly disagree	Slightly agree	Moderately agree	Strongly agree

2. I would be concerned that Robert would feel that I had deceived him about my ethical and legal obligations as a therapist. (Circle only one number.)

1	2	3	4	5	6
Strongly disagree	Moderately disagree	Slightly disagree	Slightly agree	Moderately agree	Strongly agree

3. I would be concerned that I had not acted responsibly or ethically toward my client. (Circle only one number.)

1	2	3	4	5	6
Strongly disagree	Moderately disagree	Slightly disagree	Slightly agree	Moderately agree	Strongly agree

[Please go to inside.]

4. I would be concerned that my behavior regarding informing Robert of confidentiality limits could adversely affect the therapeutic relationship. (Circle only one number.)

1	2	3	4	5	6
Strongly disagree	Moderately disagree	Slightly disagree	Slightly agree	Moderately agree	Strongly agree

5. I believe that my professional colleagues would question or criticize my behavior regarding informing Robert of confidentiality limits. (Circle only one number.)

1	2	3	4	5	6
Strongly disagree	Moderately disagree	Slightly disagree	Slightly agree	Moderately agree	Strongly agree

6. In retrospect, I would feel regretful or guilty regarding my behavior toward my client. (Circle only one number.)

1	2	3	4	5	6
Strongly disagree	Moderately disagree	Slightly disagree	Slightly agree	Moderately agree	Strongly agree

Please answer the following questions, again from your perspective as Dr. H.

7. How likely would you be to make a report of child maltreatment/abuse during or after this first session with Robert? (Circle only one number.)

1	2	3	4	5	6
Very unlikely	Somewhat unlikely	Slightly unlikely	Slightly likely	Somewhat likely	Very likely

8. How comfortable would you be with your decision to report/not report? (Circle only one number.)

1	2	3	4	5	6
Very uncomfortable	Somewhat uncomfortable	Slightly uncomfortable	Slightly comfortable	Somewhat comfortable	Very comfortable

9. How certain are you that Robert is mistreating/abusing his child? (Circle only one number.)

1	2	3	4	5	6
Very uncertain	Somewhat uncertain	Slightly uncertain	Slightly certain	Somewhat certain	Very certain

10. How would you describe Robert's behavior toward his son? (Circle only one number.)

1	2	3	4	5	6
Not at all abusive	Minimally abusive	Moderately abusive	Quite abusive	Very abusive	Extremely abusive

11. How certain are you that Robert's child is at risk for physical harm? (Circle only one number.)

1	2	3	4	5	6
Very uncertain	Somewhat uncertain	Slightly uncertain	Slightly certain	Somewhat certain	Very certain

Please indicate the extent to which you agree/disagree with the following statements regarding your work with Robert.

12. I believe that reporting this case to Child Protective Services could adversely affect my client Robert's treatment. (Circle only one number.)

1	2	3	4	5	6
Strongly disagree	Moderately disagree	Slightly disagree	Slightly agree	Moderately agree	Strongly agree

13. I believe that reporting this case to Child Protective Services could jeopardize the safety of Robert's child, Steven. (Circle only one number.)

1	2	3	4	5	6
Strongly disagree	Moderately disagree	Slightly disagree	Slightly agree	Moderately agree	Strongly agree

14. I believe that I could handle this case most effectively without the intervention of Child Protective Services. (Circle only one number.)

- | | | | | | |
|----------------------|------------------------|----------------------|-------------------|---------------------|-------------------|
| 1 | 2 | 3 | 4 | 5 | 6 |
| Strongly
disagree | Moderately
disagree | Slightly
disagree | Slightly
agree | Moderately
agree | Strongly
agree |

15. To what extent do you think Robert is aware of the limits of confidentiality in therapy? (Circle only one number.)

- | | | | | | |
|---------------------|-------------------|-------------------|----------------|-----------------|---------------------|
| 1 | 2 | 3 | 4 | 5 | 6 |
| Not at all
aware | Slightly
aware | Somewhat
aware | Quite
aware | Highly
aware | Completely
aware |

Please tell us about yourself and your practice by answering the following questions. Your responses will help us to interpret survey results. (Again, please do not write any individual identifying information on this survey.)

16. Sex: ☐ a. Male ☐ b. Female

17. Highest degree achieved (check only one):

- ☐ a. Ph.D. ☐ b. Ed.D. ☐ c. Psy.D. ☐ d. MA/MS ☐ e. M.S.W. ☐ f. Other (specify) _____

18. How many years have you been a practicing mental health professional? _____ years

19. In what state do you currently practice? _____

20. In what field(s) are you licensed? (Check all that apply.)

- | | |
|---|---|
| <input type="checkbox"/> a. Psychology | <input type="checkbox"/> c. Family Therapy |
| <input type="checkbox"/> Master's level | <input type="checkbox"/> Master's level |
| <input type="checkbox"/> Doctoral level | <input type="checkbox"/> Doctoral level |
| <input type="checkbox"/> b. Social Work | <input type="checkbox"/> d. Other (specify) _____ |
| <input type="checkbox"/> Master's level | <input type="checkbox"/> Master's level |
| <input type="checkbox"/> Doctoral level | <input type="checkbox"/> Doctoral level |

21. Please select your primary theoretical orientation. (Check only one.)

- | | |
|--|---|
| <input type="checkbox"/> a. Behavioral | <input type="checkbox"/> e. Psychodynamic |
| <input type="checkbox"/> b. Cognitive/Rational emotive | <input type="checkbox"/> f. Systems/Family |
| <input type="checkbox"/> c. Eclectic | <input type="checkbox"/> g. Other (specify) _____ |
| <input type="checkbox"/> d. Humanistic/Existential | |

22. Check the primary setting in which you practice. (Check only one.)

- | | |
|---|--|
| <input type="checkbox"/> a. Community mental health center | <input type="checkbox"/> f. University counseling center |
| <input type="checkbox"/> b. General medical center | <input type="checkbox"/> g. Forensic setting/Correctional facility |
| <input type="checkbox"/> c. Psychiatric medical center | <input type="checkbox"/> h. VA medical center |
| <input type="checkbox"/> d. Private or group practice | <input type="checkbox"/> i. Other (specify) _____ |
| <input type="checkbox"/> e. Child/adolescent/family guidance center | |

23. Please indicate how often your agency provides information regarding confidentiality to clients prior to or during their first session. (Check only one.)

- ☐ a. Always (100% of the time)
- ☐ b. Usually (estimate percentage of the time _____ %)
- ☐ c. Sometimes (estimate percentage of the time _____ %)
- ☐ d. Rarely (estimate percentage of the time _____ %)
- ☐ e. Never (0% of the time)

[Please go to back.]

24. Please indicate how often you personally provide information regarding confidentiality to your therapy clients prior to or during their first session. (Check only one.)

- ☐ a. Always (100% of the time)
☐ b. Usually (estimate percentage of the time _____ %)
☐ c. Sometimes (estimate percentage of the time _____ %)
☐ d. Rarely (estimate percentage of the time _____ %)
☐ e. Never (0% of the time)


25. What information regarding confidentiality is given to clients? (Check only one.)

- ☐ a. Clients are told that everything is confidential.
☐ b. Clients are told that there may be limits to confidentiality (without specifying what those limits might be).
☐ c. Clients are told that confidentiality might be breached in cases of (check all that apply):
☐ threatened harm to self
☐ threatened harm to others
☐ suspected child abuse
☐ other (specify) _____

Research suggests that clinicians sometimes feel ambivalent or unsure about reporting suspected child abuse. Please respond to the following questions.

[Note: If you have not had a case in the last three years in which you suspected child abuse, please go to question #27.]

26. Please estimate the number of times in your clinical work over the last three years that you have suspected incidents of child abuse.

 **IMPORTANT!** Please exclude incidents of abuse that were previously brought to the attention of Child Protective Services by someone else (i.e., incidents that occurred and were reported before you had contact with the client).

- a. I have suspected approximately _____ incidents of child abuse over the last three years.
b. I have chosen to report approximately _____ of these incidents to Child Protective Services or a similar agency over the last three years.

27. To what extent do you feel it is important to strictly adhere to your state's child abuse reporting laws? (Circle only one number.)

- | | | | | | |
|-----------|-----------|-----------|-------------|-------------|-------------|
| 1 | 2 | 3 | 4 | 5 | 6 |
| Very | Somewhat | Slightly | Slightly | Somewhat | Very |
| important | important | important | unimportant | unimportant | unimportant |

If you wish, please comment on the scenario and/or elaborate on your responses below. Add a separate sheet if necessary.

Thank you for completing this survey. Please (1) return the completed survey in the postage-paid envelope provided, and (2) send the blue response card separately to ensure your anonymity. You may contact the principal investigator by mail at the following address: Katherine Nicolai, M.S., Department of Psychology, W113 Lagomarcino Hall, Iowa State University, Ames, IA 50011-3180.

Condition Two: Low Severity/No Inform**Please carefully read the following scenario:**

Dr. H. is a licensed psychologist working in a small group practice in a metropolitan area. He/she has received a referral from a colleague and today is meeting with the client for the first time. The client, Robert, is a 36-year-old man who presents with complaints of depression. Prior to this point, Robert has never received counseling or therapy. Robert and his wife have two children: Steven (age 10) and Michael (age 6). During the course of the interview, Robert states that over the past six months, Steven has become very defiant. He "talks back all the time" at home and has started several physical fights with his younger brother. At this point in the interview, Dr. H. begins to gather more information about Steven's behavior problems and how they are handled at home.

Dr. H.: What happens after Steven misbehaves or talks back at home?

Robert: Well, it drives me nuts. I have enough to worry about without him acting up all the time. The kid just doesn't seem to know when to quit. But I make sure he thinks twice about talking back to me again.

Dr. H.: How do you make sure of that?

Robert: I pull down his pants and give him a good whipping. After a few minutes of that, he doesn't talk back, believe me.

Dr. H.: After you whip him, do you notice marks or bruises on his behind?

Robert: I don't know...maybe, sometimes. But listen, doctor, it's the only way he learns anything! Believe me, a few marks on his behind is nothing compared to what I feel like doing sometimes.

Dr. H. must now decide whether to make a report of maltreatment/abuse to Child Protective Services. **Dr. H. has NOT informed Robert of the limits of confidentiality**, including the fact that Dr. H. is legally obligated to report suspected child maltreatment/abuse.

Condition Three: High Severity/Inform**Please carefully read the following scenario:**

Dr. H. is a licensed psychologist working in a small group practice in a metropolitan area. He/she has received a referral from a colleague and today is meeting with the client for the first time. The client, Robert, is a 36-year-old man who presents with complaints of depression. Prior to this point, Robert has never received counseling or therapy. Robert and his wife have two children: Steven (age 10) and Michael (age 6). During the course of the interview, Robert states that over the past six months, Steven has become very defiant. He "talks back all the time" at home and has started several physical fights with his younger brother. At this point in the interview, Dr. H. begins to gather more information about Steven's behavior problems and how they are handled at home.

Dr. H.: What happens after Steven misbehaves or talks back at home?

Robert: Well, it drives me nuts. I have enough to worry about without him acting up all the time. The kid just doesn't seem to know when to quit. But I make sure he thinks twice about talking back to me again.

Dr. H.: How do you make sure of that?

Robert: I pull down his pants and give him a good whipping. After a few minutes of that, he doesn't talk back, believe me.

Dr. H.: After you whip him, do you notice marks or bruises on his behind?

Robert: I don't know...maybe, sometimes. But listen, doctor, it's the only way he learns anything! Believe me, a few marks on his behind is nothing compared to what I feel like doing sometimes. Last week he was really out of control and I gave him a black eye by mistake. The kid just doesn't seem to learn.

Dr. H. must now decide whether to make a report of maltreatment/abuse to Child Protective Services. Dr. H. HAS informed Robert of the limits of confidentiality, including the fact that Dr. H. is legally obligated to report suspected child maltreatment/abuse.

Condition Four: High Severity/No Inform**Please carefully read the following scenario:**

Dr. H. is a licensed psychologist working in a small group practice in a metropolitan area. He/she has received a referral from a colleague and today is meeting with the client for the first time. The client, Robert, is a 36-year-old man who presents with complaints of depression. Prior to this point, Robert has never received counseling or therapy. Robert and his wife have two children: Steven (age 10) and Michael (age 6). During the course of the interview, Robert states that over the past six months, Steven has become very defiant. He "talks back all the time" at home and has started several physical fights with his younger brother. At this point in the interview, Dr. H. begins to gather more information about Steven's behavior problems and how they are handled at home.

Dr. H.: What happens after Steven misbehaves or talks back at home?

Robert: Well, it drives me nuts. I have enough to worry about without him acting up all the time. The kid just doesn't seem to know when to quit. But I make sure he thinks twice about talking back to me again.

Dr. H.: How do you make sure of that?

Robert: I pull down his pants and give him a good whipping. After a few minutes of that, he doesn't talk back, believe me.

Dr. H.: After you whip him, do you notice marks or bruises on his behind?

Robert: I don't know...maybe, sometimes. But listen, doctor, it's the only way he learns anything! Believe me, a few marks on his behind is nothing compared to what I feel like doing sometimes. Last week he was really out of control and I gave him a black eye by mistake. The kid just doesn't seem to learn.

Dr. H. must now decide whether to make a report of maltreatment/abuse to Child Protective Services. **Dr. H. has NOT informed Robert of the limits of confidentiality**, including the fact that Dr. H. is legally obligated to report suspected child maltreatment/abuse.

APPENDIX C
REGRESSION TABLES

Table C1.

Relation of Dissonance to Demographic and Practice Variables

Variable	B	SE B	B	T
Sex	-0.11	0.14	-.06	-0.79
State				
Arkansas	-0.26	0.20	-.11	-1.32
Connecticut	-0.27	0.16	-.14	-1.72
New Mexico				
Setting	0.01	0.14	.01	0.01
Years experience	-0.01	0.01	-.11	-1.56
Reporting history				
Consistent reporter	-0.20	0.17	-.10	-1.25
Inconsistent reporter	-0.37	0.17	-.16	-2.12
Nonsuspector				
Theoretical orientation				
Cognitive & Behavioral	-0.12	0.20	-.06	-0.61
Eclectic	0.14	0.19	.07	0.72
Psychodynamic	-0.09	0.21	-.04	-0.46
Other				
Information Provision	0.09	0.06	.10	1.49

Note. A nonsignificant effect for abuse severity was observed, $F(22,208)=.99$, $p>.10$. $R^2 = .05$, $F(11,219)=1.10$, $p>.10$.

Table C2.

Relation of Abuse Certainty to Demographic and Practice Variables: Low Severity Submodel

Variable	B	SE B	B	T
Sex	0.56	0.65	.09	0.87
State				
Arkansas	-0.82	0.88	-.11	-0.93
Connecticut	-0.23	0.73	-.04	-0.31
New Mexico				
Setting	-0.49	0.63	-.08	-0.78
Years experience	-0.03	0.04	-.09	-0.80
Reporting history				
Consistent reporter	-0.46	0.75	-.07	-0.61
Inconsistent reporter	0.02	0.83	.00	0.03
Nonsuspector				
Theoretical orientation				
Cognitive & Behavioral	-1.69	0.94	-.26	-1.79
Eclectic	-1.51	0.92	-.23	-1.64
Psychodynamic	-1.73	1.01	-.25	-1.71
Other				
Information Provision	0.27	0.29	.09	0.91

Note. A significant effect for abuse severity was observed, $F(22,208)=3.73$, $p<.0001$. $R^2 = .09$, $F(11,96)=.82$, $p>.10$.

Table C3.

Relation of Abuse Certainty to Demographic and Practice Variables: High Severity Submodel

Variable	B	SE B	B	T
Sex	-0.09	0.47	-.02	-0.19
State				
Arkansas	-1.38	0.71	-.21	-1.90
Connecticut	-1.64	0.53	-.32	-3.07**
New Mexico				
Setting	0.00	0.47	.00	-0.00
Years experience	-0.07	0.03	-.26	-2.68**
Reporting history				
Consistent reporter	0.12	0.52	.02	0.23
Inconsistent reporter	-0.38	0.60	-.06	-0.64
Nonsuspector				
Theoretical orientation				
Cognitive & Behavioral	-0.71	0.69	-.12	-1.03
Eclectic	0.56	0.66	.10	0.85
Psychodynamic	0.41	0.68	.07	0.61
Other				
Information Provision	0.38	0.22	.16	1.78

Note. A significant effect for abuse severity was observed, $F(22,208)=3.73$, $p<.0001$. $R^2 = .18$, $F(11,111)=2.15$, $p<.05$.

* $p < .05$

** $p < .01$

*** $p < .001$

Table C4.

Relation of Reporting to Demographic and Practice Variables:
Low Severity Submodel

Variable	B	SE B	B	T
Sex	-0.08	0.37	-.02	-0.20
State				
Arkansas	-0.38	0.50	-.09	-0.76
Connecticut	-0.30	0.42	-.08	-0.72
New Mexico				
Setting	0.23	0.36	.06	0.64
Years experience	-0.07	0.02	-.32	-3.07**
Reporting history				
Consistent reporter	0.91	0.43	.24	2.12*
Inconsistent reporter	0.02	0.47	.01	0.05
Nonsuspector				
Theoretical orientation				
Cognitive & Behavioral	0.03	0.54	.01	0.06
Eclectic	-0.20	0.52	-.05	-0.39
Psychodynamic	-0.24	0.57	-.06	-0.41
Other				
Information Provision	0.19	0.17	.11	1.13

Note. A significant effect for abuse severity was observed, $F(22,207)=3.20$, $p<.0001$. $R^2 = .20$, $F(11,95)=2.17$, $p<.05$.

* $p < .05$

** $p < .01$

*** $p < .001$

Table C5.

Relation of Reporting to Demographic and Practice Variables:
High Severity Submodel

Variable	B	SE B	B	T
Sex	0.00	0.29	.00	0.01
State				
Arkansas	-0.84	0.44	-.21	-1.93
Connecticut	-0.79	0.33	-.25	-2.41*
New Mexico				
Setting	0.42	0.29	.13	1.49
Years experience	-0.04	0.02	-.21	-2.15*
Reporting history				
Consistent reporter	0.12	0.32	.04	0.38
Inconsistent reporter	-1.02	0.37	-.26	-2.77**
Nonsuspector				
Theoretical Orientation				
Cognitive & Behavioral	-0.42	0.43	-.11	-0.98
Eclectic	0.34	0.41	.10	0.84
Psychodynamic	-0.06	0.42	-.02	-0.15
Other				
Information Provision	0.24	0.13	.16	1.78

Note. A significant effect for abuse severity was observed, $F(22,207)=3.20$, $p<.0001$. $R^2 = .22$, $F(11,111)=2.89$, $p<.01$.

* $p < .05$
 ** $p < .01$
 *** $p < .001$

Table C6.

Relation of CPS-Unnecessary^a to Demographic and Practice Variables

Variable	B	SE B	B	T
Sex	-0.19	0.22	-.06	-0.84
State				
Arkansas	-0.02	0.32	-.01	-0.07
Connecticut	-0.09	0.25	-.03	-0.35
New Mexico				
Setting	-0.33	0.22	-.10	-1.50
Years experience	0.01	0.01	.08	1.14
Reporting history				
Consistent reporter	-0.49	0.25	-.15	-1.94
Inconsistent reporter	0.00	0.28	.00	0.02
Nonsuspector				
Theoretical orientation				
Cognitive & Behavioral	0.08	0.33	.02	0.25
Eclectic	0.25	0.31	.07	0.80
Psychodynamic	-0.11	0.33	-.03	-0.35
Other				
Information Provision	-0.02	0.10	-.01	-0.18

Note. A nonsignificant effect for abuse severity was observed, $F(22,206)=1.02$, $p>.10$. $R^2 = .06$, $F(11,217)=1.26$, $p>.10$.

^a Belief that case could be handled most effectively without CPS intervention (Appendix B, item 14)

Table C7.

Relation of CPS-Robert^a to Demographic and Practice Variables

Variable	B	SE B	B	T
Sex	-0.17	0.19	-.07	-0.92
State				
Arkansas	-0.05	0.27	-.02	-0.19
Connecticut	-0.22	0.21	-.09	-1.07
New Mexico				
Setting	-0.03	0.18	-.01	-0.16
Years experience	-0.00	0.01	-.01	-0.20
Reporting history				
Consistent reporter	-0.56	0.21	-.20	-2.66
Inconsistent reporter	0.12	0.23	.04	0.53
Nonsuspector				
Theoretical orientation				
Cognitive & Behavioral	-0.46	0.27	-.16	-1.68
Eclectic	-0.09	0.26	-.03	-0.33
Psychodynamic	-0.32	0.28	-.10	-1.14
Other				
Information Provision	-0.02	0.09	-.01	-0.18

Note. A nonsignificant effect for abuse severity was observed, $F(22,207)=1.04$, $p>.10$. $R^2 = .07$, $F(11,218)=1.45$, $p>.10$.

^a Belief that Robert would be adversely affected by CPS intervention (Appendix B, item 12)

Table C8

Relation of CPS-Steven^a to Demographic and Practice Variables:
High Severity Submodel

Variable	B	SE B	B	T
Sex	0.59	0.25	.23	2.34
State				
Arkansas	0.71	0.38	.21	1.86
Connecticut	0.11	0.29	.04	0.40
New Mexico				
Setting	0.04	0.25	.02	0.17
Years experience	0.01	0.01	.07	0.72
Reporting history				
Consistent reporter	-0.29	0.28	-.11	-1.04
Inconsistent reporter	0.03	0.32	.01	0.10
Nonsuspector				
Theoretical Orientation				
Cognitive & Behavioral	-0.65	0.37	-.22	-1.75
Eclectic	-0.05	0.35	-.02	-0.13
Psychodynamic	-0.42	0.37	-.14	-1.15
Other				
Information Provision	0.08	0.12	.07	0.69

Note. A significant effect for abuse severity was observed, $F(22,207)=2.03$, $p<.01$. $R^2 = .12$, $F(11,111)=1.37$, $p>.10$.

^a Belief that Steven's safety would be jeopardized by CPS intervention (Appendix B, item 13)

Table C9.

Relation of CPS-Steven^a to Demographic and Practice Variables:
Low Severity Submodel

Variable	B	SE B	<i>B</i>	T
Sex	0.51	0.26	.20	1.96
State				
Arkansas	0.22	0.35	.07	0.64
Connecticut	-0.51	0.29	-.19	-1.74
New Mexico				
Setting	-0.40	0.25	-.15	-1.59
Years experience	-0.02	0.01	-.14	-1.36
Reporting history				
Consistent reporter	-0.15	0.30	-.05	-0.49
Inconsistent reporter	0.28	0.32	.10	0.85
Nonsuspector				
Theoretical orientation				
Cognitive & Behavioral	-0.82	0.37	-.29	-2.21*
Eclectic	-0.57	0.36	-.20	-1.57
Psychodynamic	-0.82	0.40	-.27	-2.05*
Other				
Information Provision	-0.00	0.12	-.00	-0.03

Note. A nonsignificant effect for abuse severity was observed, $F(22,207)=2.03$, $p>.10$. $R^2 = .26$, $F(11,95)=3.00$, $p<.01$.

^a Belief that Steven's safety would be jeopardized by CPS intervention (Appendix B, item 13)

* $p < .05$

** $p < .01$

*** $p < .001$

Table C10.

Relation of Client Awareness to Demographic and Practice Variables

Variable	B	SE B	B	T
Sex	0.02	0.14	.01	0.17
State				
Arkansas	-0.53	0.20	-.22	-2.64
Connecticut	-0.25	0.16	-.13	-1.57
New Mexico				
Setting	0.09	0.14	.04	0.62
Years experience	-0.01	0.01	-.10	-1.34
Reporting history				
Consistent reporter	-0.01	0.16	-.00	-0.04
Inconsistent reporter	0.24	0.18	.11	1.37
Nonsuspector				
Theoretical Orientation				
Cognitive & Behavioral	-0.05	0.20	-.02	-0.23
Eclectic	0.23	0.20	.01	0.10
Psychodynamic	-0.08	0.21	-.04	-0.39
Other				
Information Provision	-0.02	0.06	-.02	-0.31

Note. A nonsignificant effect for abuse severity was observed, $F(22,208)=1.06$, $p>.10$. $R^2 = .05$, $F(11,219)=1.13$, $p>.10$.

^a Belief that case could be handled most effectively without CPS intervention (Appendix B, item 14)

* $p < .05$
 ** $p < .01$
 *** $p < .001$